CCME

2018 External Quality Review

WELLCARE OF SOUTH CAROLINA

Submitted: January 10, 2019

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and results of the *2018 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review details the level of performance demonstrated by WellCare of South Carolina (WellCare) since the 2017 annual review.

The goals of the review are to:

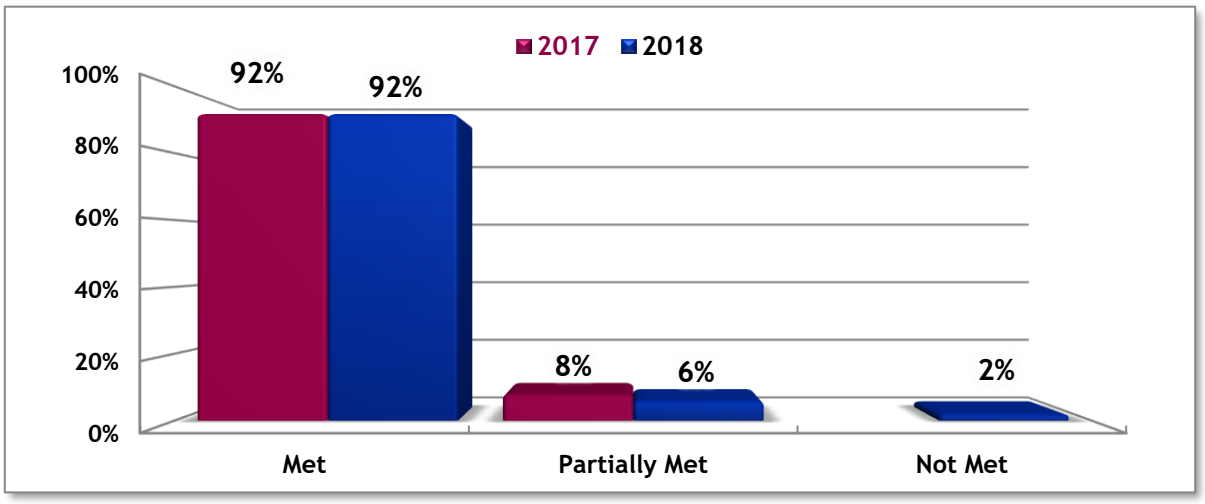
- Determine if WellCare is in compliance with service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2017 annual review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback about potential areas of further improvement
- Validate contracted health care services were delivered and of good quality

The process CCME used for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects (PIPs), validation of performance measures, and satisfaction survey validation.

Overall Findings

The 2018 annual review shows that WellCare achieved a "Met" score for 92% of the standards reviewed. As the following chart indicates, 6% of the standards are scored as "Partially Met," and 2% of the standards score as "Not Met." The chart that follows provides a comparison of WellCare's current review results to the 2017 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable corrective action items and recommendations are found in the narrative of this report under each respective topic area.

Administration

All contractually required positions are filled. Sonya Nelson, the Plan President for WellCare's Georgia plan, is acting as the Interim Plan President for WellCare of South Carolina. Staff reported the Plan President position is expected to be filled within the next 30 days.

CCME's review of WellCare's organizational chart and associated onsite discussion found the organizational chart was not updated to reflect current staff in several positions.

Overall, WellCare's *Information Systems Capability Assessment* documentation indicates the plan can satisfy the requirements of the *SCDHHS Contract*. A robust security standard that communicates clear and concise security guidance to staff and contractors is in place. Disaster recovery documentation indicates WellCare performed system recovery operations to a separate data center; although this is resource intensive, it tends to be more thorough than a "tabletop" disaster recovery test.

CCME's review of WellCare's *Compliance Plan* confirms that all required queries for exclusion status monitoring for South Carolina are not included. Also, the *South Carolina Pharmacy Lock-In Program* policy within the *Compliance Plan* incorrectly documents requirements for member notification of placement in the Pharmacy Lock-In Program.

Provider Services

The Credentialing Committee, chaired by Dr. Robert London, Senior Medical Director, includes four network physicians and a licensed clinical social worker representing behavioral health. Meeting minutes indicate that two physicians did not appear to attend committee meetings frequently. Dr. London indicated during the onsite visit that he discussed attendance issues and members are working on improving attendance.

A review of the credentialing program showed various queries are missing in some of the policies. During the onsite discussion, WellCare indicated it is not currently performing federal and state database checks for persons identified on ownership disclosure forms with an ownership or controlling interest as required. WellCare recognizes this issue and is developing a process that is scheduled for implementation during the first quarter of 2019.

WellCare's GeoAccess reporting policy has an outdated table that shows required network providers. During the onsite visit, WellCare indicated it will begin using the provider taxonomy number in assessing compliance with the SCDHHS provider network requirements. CCME suggests WellCare include or develop a policy that describes the WellCare network evaluation process.

Provider access and availability is monitored semi-annually by a contracted vendor. However, WellCare's appointment and after-hours policy needs to be updated to address the goal that providers must achieve to be considered compliant.

Results of the Telephonic Provider Access Study conducted by CCME shows calls are answered successfully 68% of the time. When compared to 2017 results of 60%, the 2018 study has a statistically significant increase in successful calls.

Member Services

WellCare policies have discrepancies in the timeframe to send new member materials. During onsite discussion of this issue, there was disagreement among WellCare staff about the timeframe. In addition, the plan's staff informed CCME that as of mid-year 2018, WellCare no longer mails a *Member Handbook* to new members; instead, the plan mails a *Quick Start Guide*. Plan policies do not reflect this process change.

WellCare has engaged a vendor, Teleperformance, to provide Member Services call center functions and conducts oversight to ensure the vendor's compliance with contractual obligations. CCME's review confirms all required call center functions are conducted.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continues to be conducted annually via a third-party vendor. The 2018 survey response rates increased for all survey categories; however, response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.

CCME noted and discussed issues during the onsite visit related to WellCare's documentation of grievance processes and requirements in policies, handbooks, etc. A few isolated issues of concern are noted in grievance files and CCME discussed these issues with WellCare staff during the onsite visit. Utilization Management Advisory Committee meeting minutes reveal WellCare does not report grievance data and information to the committee consistently as defined in policy. This data is also not updated in the *2018 Quality Improvement Work Plan*.

Quality Improvement

WellCare's *2018 Medicaid Quality Improvement Program Description* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The Quality Improvement Committee (QIC) provides oversight and approval of all QI activities. The Utilization Management Advisory Committee (UMAC) oversees all clinical QI, utilization management, and behavioral health activities. The primary responsibilities for both committees are outlined in the QI Program Description.

Monitoring provider compliance with preventative health and clinical practice guidelines was added as an objective for the QI Program. The *2018 QI Work Plan* addresses monitoring compliance with the guidelines; however, the specific guidelines monitored are not addressed, and the monitoring frequency is listed as quarterly, yet "N/A" is recorded for the first, second, and third quarters. WellCare evaluates the effectiveness of its QI Program annually. For this review, the health plan provided the *2017 Medicaid Quality Improvement Program Evaluation*. This report provides an assessment of the results of the QI activities conducted during 2017. Some of the reported results appear incomplete or incorrect.

Performance measures and performance improvement projects met the CMS validation requirements. Comparison of the Healthcare Effectiveness Data and Information Set (HEDIS) measures from the previous year to the current year reveal a strong increase (>10%) in several measures including Combination 1 Immunizations, Lead Screening, and Medication Management for People with Asthma. One measure, Persistence of Beta-Blocker Treatment After a Heart Attack reflects a substantial (>10%) decrease in the reported rate. (see *Table 1: HEDIS Measures*).

Table 1: HEDIS Measures

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Substantial Increase in Rate (>10% improvement)			
Immunizations for Adolescents			
Combination #1	12.27%	24.82%	12.55%
Lead Screening in Children	11.81%	23.36%	11.55%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	50.36%	61.51%	11.15%
Medication Management for People with Asthma			
12-18 Years - Medication Compliance 75%	12.65%	22.89%	10.24%
51-64 Years - Medication Compliance 75%	20.00%	37.50%	17.50%
Comprehensive Diabetes Care			
Blood Pressure Control (<140/90 mm Hg)	43.44%	55.23%	11.79%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
12-17 Years	39.39%	52.94%	13.55%
Adolescent Well-Care Visits	41.67%	53.04%	11.37%
Substantial Decrease in Rate (>10% decrease)			
Persistence of Beta-Blocker Treatment After a Heart Attack	76.92%	62.50%	-14.42%

WellCare reports 12 quality clinical withhold measures for 2017. As per the *SCDHHS Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile=1 point; 10-24 %=2 points; 25-49=3 points; 50-74 % = 4 points; 75-90 % = 5 points; >90 % 6 points). Points attained for each measure are multiplied by individual measure weights, then summed to obtain a quality index score. The 2017 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Diabetes measure rates generate the highest index score, followed by Women's Health, and Pediatric Preventive Care.

Table 2: Quality Withhold Measures

Measure	2017 Rate	2017 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	88.08%	75	5.00	4.25
HbA1c Control (< =9)	53.04%	50	4.00	
Eye Exam (Retinal) Performed	41.36%	10	2.00	
Medical Attention for Nephropathy	92.70%	75	5.00	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	89.76%	75	5.00	4
Breast Cancer Screen	53.68%	25	3.00	
Cervical Cancer Screen	55.04%	25	3.00	
Chlamydia Screen in Women (Total)	60.36%	50	4.00	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	65.58%	50	4.00	3
Well Child Visits in 3rd,4th,5th&6th Years of Life	57.86%	<10	1.00	
Adolescent Well-Care Visits	53.04%	50	4.00	
Weight Assessment/Adolescents: BMI % Total	72.99%	25	3.00	

Three projects were submitted and validated using the *CMS Protocol for Validation of Performance Improvement Projects*. They are *Improving Dilated Retinal Exam (DRE) Screening*, *Access to Care*, and *Improving Hemoglobin A1C Testing*. The three projects receive a validation score within the High Confidence range. *Table 3: Performance Improvement Project Validation Scores* provides an overview of each project's validation score.

TABLE 3: Performance Improvement Project Validation Scores

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Improving Dilated Retinal Exam (DRE) Screening	Not Validated	78/78=100% High Confidence in Reported Results
Access to Care	78/78=100% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results
Improving Hemoglobin A1C Testing	91/91=100% High Confidence in Reported Results	90/91=99% High Confidence in Reported Results

Utilization Management

CCME's assessment of utilization management (UM) includes reviews of program descriptions, program evaluations, policies, *Member Handbook*, *Provider Manual*, and approval, denial, appeal and case management files. Policies and procedures define how UM, medical necessity determinations, appeals, and CM services are operationalized and provided to members. The *Member Handbook* incorrectly lists the requirement for a member to request an extension of an expedited service authorization. During the file review, CCME identified issues with timeframes for when member appeals are received and processed. *Policy SC22-RX-012, Pharmacy Appeals* reflects incorrect terminology such as "adverse coverage determination" and "redetermination" that are not consistent with *SCDHHS Contract* terminology.

The *UM Program Description* outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. The Care Management Population Health model, implemented in October 2017, integrates the Disease Management (DM) and Care Management (CM) programs to provide holistic services addressing all risk levels. During the onsite visit, WellCare reported positive results recognized from this implementation.

Delegation

WellCare has delegated entities in the service areas of UM, nurse advice line, pharmacy, customer service, crisis line, case management, vision, and credentialing. Written agreements are in place for all entities performing delegated services. WellCare's policy and procedure for delegation oversight has some incorrect references that need updating. CCME received proof of annual or pre-delegation oversight activities for all delegated entities. Overall improvement from the 2017 EQR is seen in the oversight

activities; however, the 2018 credentialing/recredentialing review form does not address all required queries.

State Mandated Services

Provider compliance with provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations is monitored through medical record reviews conducted by nurse reviewers. WellCare provides all core benefits specified by the *SCDHHS Contract*.

*Table 4: Scoring Ov*erview displays the findings of the 2018 annual review compared to the findings of the 2017 review.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2017	39	0	0	0	0	39
2018	38	2	0	0	0	40
Provider Services						
2017	71	7	0	0	0	78
2018	70	4	4	0	0	78
Member Services						
2017	30	3	0	0	0	33
2018	29	4	0	0	0	33
Quality Improvement						
2017	15	0	0	0	0	15
2018	15	0	0	0	0	15
Utilization						
2017	39	6	0	0	0	45
2018	43	2	0	0	0	45
Delegation						
2017	1	1	0	0	0	2
2018	1	1	0	0	0	2

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
State Mandated Services						
2017	4	0	0	0	0	4
2018	3	0	1	0	0	4

METHODOLOGY

The process used by CCME for the EQR activities was based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review (EQR) of a Medicaid Managed Care Organization (MCO)/Prepaid Inpatient Health Plan (PIHP) and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On October 22, 2018, CCME sent notification to WellCare that it was initiating the annual EQR (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow WellCare to ask questions regarding the EQR process and the desk materials requested.

The review consists of two segments. The first segment was a desk review of materials and documents CCME received from WellCare on November 5, 2018; these items were reviewed in CCME's offices (see Attachment 1). These items focus on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review are credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted December 11-12, 2018, at WellCare's office in Columbia, South Carolina. The onsite visit focused on areas not covered in the desk review or items needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities include an entrance conference, interviews with WellCare's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The findings of the EQR are summarized below and are based on the regulations set forth in *Title 42* of the *Code of Federal Regulations* (CFR), *part 438*, and the contract requirements between WellCare and SCDHHS. Strengths, weaknesses and recommendations are identified where applicable. Areas of review were identified as

meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Applicable, or Not Evaluated, and are recorded in the tabular spreadsheet (*Attachment 4*).

A. Administration

The administration review of WellCare focuses on policies and procedures, staffing, information systems, compliance, program integrity (PI), and confidentiality.

WellCare of South Carolina is a subsidiary of WellCare Health Plans, Inc., headquartered in Tampa, Florida. Contractually required positions are filled; however, Sonya Nelson, the Plan President for WellCare's Georgia plan, is acting as the Interim Plan President for WellCare of South Carolina. Onsite discussion revealed WellCare is in the final stages of recruitment and hiring for a Plan President, and staff expect that the position will be filled soon, possibly within the next 30 days.

CCME's review of WellCare's organizational chart and associated onsite discussion reveal the organizational chart does not reflect current staff in several positions. An example is that Jill Resnikoff is listed as Director of Utilization Management (UM), but it was determined during the onsite visit that Kelly Jordan holds the position. The organizational chart should be updated when new staff are hired, when staff are promoted or moved into different positions, and when positions are created or eliminated.

WellCare's *Information Systems Capability Assessment* (ISCA) documentation indicates systems and functionality are in place to ensure Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic data exchange, identify members across product lines, manually review any identified member duplications, and provide reports required by the State. WellCare follows the "HITRUST Common Security Framework" and provides personnel with guidance about security controls and risk minimization. The *Information Technology Disaster Recovery Plan* addresses overall strategy, staff responsibilities, vendors, incident documentation, and response procedures. Disaster recovery plan testing conducted in February 2018 resulted in successful recovery of all critical systems. Results of security assessments of WellCare's public facing member portals indicate vulnerabilities; however, no documented corrective measures were provided. CCME recommends WellCare document planned or completed corrective measures. Although not an ISCA or *SCDHHS Contract* requirement, this action demonstrates an ongoing focus on security improvements.

WellCare's *Compliance Plan*, along with associated policies and procedures, details compliance processes and requirements. However, the *WellCare Corporate Compliance Program* document within the *Compliance Plan* does not specify all required queries for South Carolina exclusion status monitoring. It does not include the *Social Security Death*

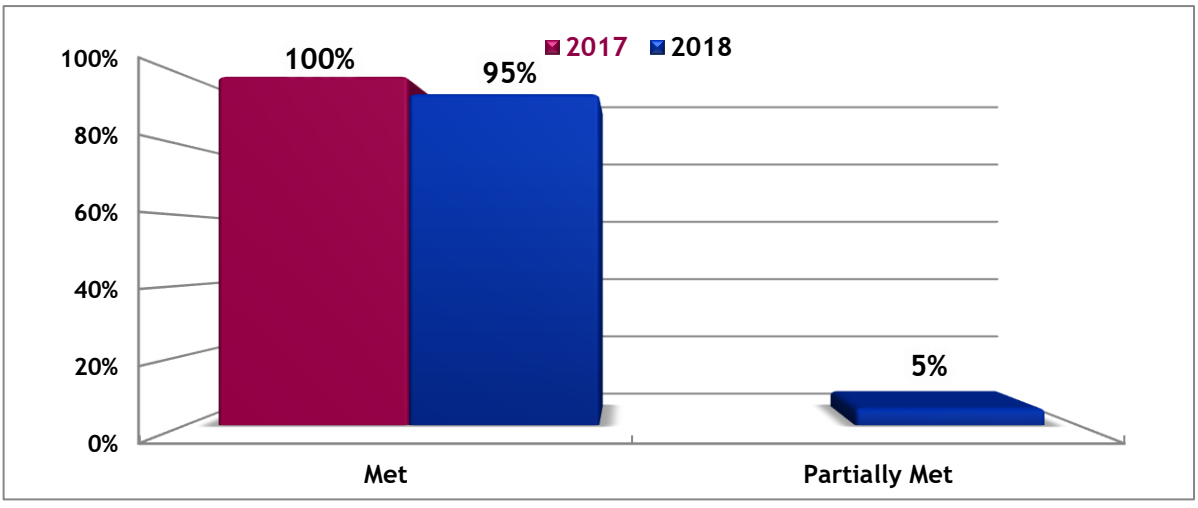
Master File, the *SC List of Excluded Providers*, the *SC List of Providers Terminated for Cause*, the *Exclusions, Suspensions, and Terminations List*, and the *Behavioral Health Actions List*.

WellCare's *Code of Conduct and Business Ethics* (Code) provides comprehensive information and guidance about standards of ethical behavior and compliance with federal and state laws. Staff are informed of the expectation to read and follow the Code. In addition, WellCare provides comprehensive compliance training to staff and network providers. The *Corporate Compliance Training Policy* defines a timeframe of within 30 days of hire for new staff to complete the full compliance training; however, onsite discussion revealed new staff receive training on compliance and confidentiality requirements during orientation on the first day of employment. The Market Compliance Oversight Committee advises and reports to the Chief Compliance Officer, the Corporate Compliance Committee, and ultimately to the Audit, Finance, and Regulatory Compliance Committee of the Board of Directors.

The *South Carolina - Pharmacy Lock-In Program* policy incorrectly states members without a physical address may be notified of their placement into the Pharmacy Lock-In Program via first class mail. This is not compliant with requirements of the *SCDHHS Contract, Section 11.10.2.1* which requires notification via certified mail. WellCare staff stated during onsite discussion that no notifications have been sent via first class mail.

As illustrated in *Figure 2: Administration Findings*, WellCare received "Met" scores for 95% of the standards in the Administration section. This represents a decrease of five percent for standards scored as "Met." Scores of "Partially Met" are due to documentation in the *Compliance Plan* related to exclusion status monitoring and an error in documentation of requirements for the Pharmacy Lock-In Program.

Figure 2: Administration Findings



Strengths

- WellCare is a member of the Healthcare Fraud Prevention Partnership, a voluntary partnership working to improve abilities to detect and prevent health care fraud by sharing data and collaborating on anti-fraud methodologies.
- Disaster recovery documentation indicates WellCare performed system recovery operations to a separate data center, which is resource intensive but tends to be more thorough than a "tabletop" disaster recovery test.
- Clean claim processing results exceed the processing times required by the *SCDHHS Contract*.

Weaknesses

- WellCare's organizational chart is not updated to reflect staff currently filling several positions.
- WellCare's security assessments of its public facing member portals indicate vulnerabilities; however, no documented corrective measures were provided.
- Onsite discussion confirmed new employees receive training on confidentiality and HIPAA compliance on the first day of employment during orientation. This is not reflected in the *Corporate Compliance Training Policy (Policy C13-CP-006)*.
- Page 14 of the *WellCare Corporate Compliance Program* indicates current and new staff, contractors, sales representatives, and agents are screened monthly against the Department of Health and Human Services Office of Inspector General's *List of Excluded Individuals/Entities*, the General Service Administration's *System for Award Management* exclusion lists, and similar state exclusion lists. The document does not specify additional required queries for South Carolina, including, but not limited to the *Social Security Death Master File*, the *SC List of Excluded Providers*, the *SC List of Providers Terminated for Cause*, the *Exclusions, Suspensions*, and *Terminations List*, and *the Behavioral Health Actions List*.
- The *South Carolina - Fraud Waste and Abuse Policy (C13-SIU-FWA-001-SC)* defines processes for fraud, waste, and abuse detection and investigation. Throughout the policy, terms such as "the Department," "Medicaid Fraud Control Unit," etc. are used without being defined as referring to SCDHHS or SCDHHS' Medicaid Fraud Control Unit.
- Item five on page two of the *South Carolina - Pharmacy Lock-In Program (Policy SC22-RX-005)* states, "New lock-in members…are notified via certified mail at least thirty (30) calendar days prior to the effective lock in date. Those members without a physical address are notified via first class mail." The *SCDHHS Contract, Section 11.10.2.1* requires that the initial notification letter and instructions for members placed into the Lock-In Program must be sent by Certified Mail.

- The *SCDHHS Contract, Section 11.10.3.5* requires health plans to allow a five-calendar day emergency supply of medication to be filled by a pharmacy other than the member's designated pharmacy in case of an emergency. The requirement to allow an emergency supply of medication to be filled by a pharmacy other than the designated lock-in pharmacy is not addressed in WellCare policy.

Quality Improvement Plans

- Update the *WellCare Corporate Compliance Program* document to include all queries required for exclusion status monitoring for South Carolina. This can be accomplished via an addendum to the document.
- Revise *Policy SC22-RX-005* to indicate initial notification letters and instructions for members placed in the Pharmacy Lock-In Program are sent to all members via certified mail.
- Include that members in the Pharmacy Lock-In Program may obtain a five-calendar day emergency supply of medication from a pharmacy other than the member's designated pharmacy in case of an emergency in *Policy SC22-RX-005*.

Recommendations

- Update the WellCare of South Carolina organizational chart routinely to reflect all staffing changes, additions, and position eliminations.
- Following a security assessment, document corrective actions that are planned or completed. Although not an ISCA or *SCDHHS Contract* requirement, this demonstrates an ongoing focus on security improvements.
- Revise *Policy C13-CP-006* to include that new employees receive training on confidentiality and HIPAA on the first day of employment.
- Revise the *South Carolina - Fraud Waste and Abuse Policy* to define terms that refer to agencies, departments, or units outside of WellCare.

B. Provider Services

CCME conducted a review of all Provider Services policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing/recredentialing files, and practice guidelines. The Credentialing Committee is chaired by Dr. Robert London, Senior Medical Director. Other voting members of the committee include four network physicians with specialties in cardiology, hematology/oncology, family medicine, and pediatrics, and a licensed clinical social worker representing behavioral health. The committee meets monthly and a quorum is met with at least two voting members plus the committee chairperson. Meeting minutes reflect a met quorum at all meetings. Two physicians do not appear to be attending the

committee meetings frequently. Dr. London indicated during the onsite visit that he has discussed their attendance issues, and they are working to improve attendance.

Several policies address requirements for initial credentialing, recredentialing, and ongoing monitoring of providers. The policies did not address all Program Integrity (PI) queries that are required by SCDHHS, such as the *Suspension List* and *Behavioral Health Actions List*. The policy relating to ongoing monitoring does not include the requirement to query the *Social Security Death Master File (SSDMF)*. This was noted as a deficiency during the previous External Quality Review. The policy was updated and submitted as part of the Quality Improvement Plan; however, the update was never implemented. The credentialing and recredentialing files do not reflect proof of the following queries: the *Termination for Cause List*, *Suspension List*, and the *Behavioral Health Actions List*.

During the onsite visit, WellCare indicated it is not currently performing federal and state database checks for persons identified on ownership disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *SCDHHS Policy and Procedure Guide, Section 11.2*. WellCare recognized this issue and has been developing a process scheduled for implementation in the first quarter of 2019.

The performance standards for determining geographic provider access for Medicaid members are defined in *Policy SC22 OP-NI-001, SC - GeoAccess Reporting*. The policy has a table of required network providers that includes the provider status code; however, this table is outdated. The *SCDHHS Policy and Procedure Guide, Section 6.2* contains the updated table of required network providers. During the onsite visit, WellCare indicated it will begin using the provider taxonomy number in assessing compliance with the *SCDHHS* provider network requirements. CCME suggests WellCare include or develop a policy that describes the WellCare network evaluation process.

WellCare conducts provider access and availability audits as reported in the *2017 Medicaid Quality Improvement Program Evaluation* and the *2017 South Carolina Medicaid-Accessibility of Services Report*. Appointment availability and after-hours access audits are performed by a contracted vendor semi-annually, and results vary by provider type and standard. Accessibility compliance for some appointment standards did not meet the health plan goal of 90%, but corrective action was addressed for non-compliant providers per the onsite visit discussion. A *Provider Relations Action Plan* is detailed in the *2017 South Carolina Medicaid-Accessibility of Services Report*. CCME suggests that WellCare update its appointment and after-hour's policy to address the goal that providers must achieve to be considered in compliance.

Provider Access and Availability Study

As part of the annual EQR process for WellCare, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by

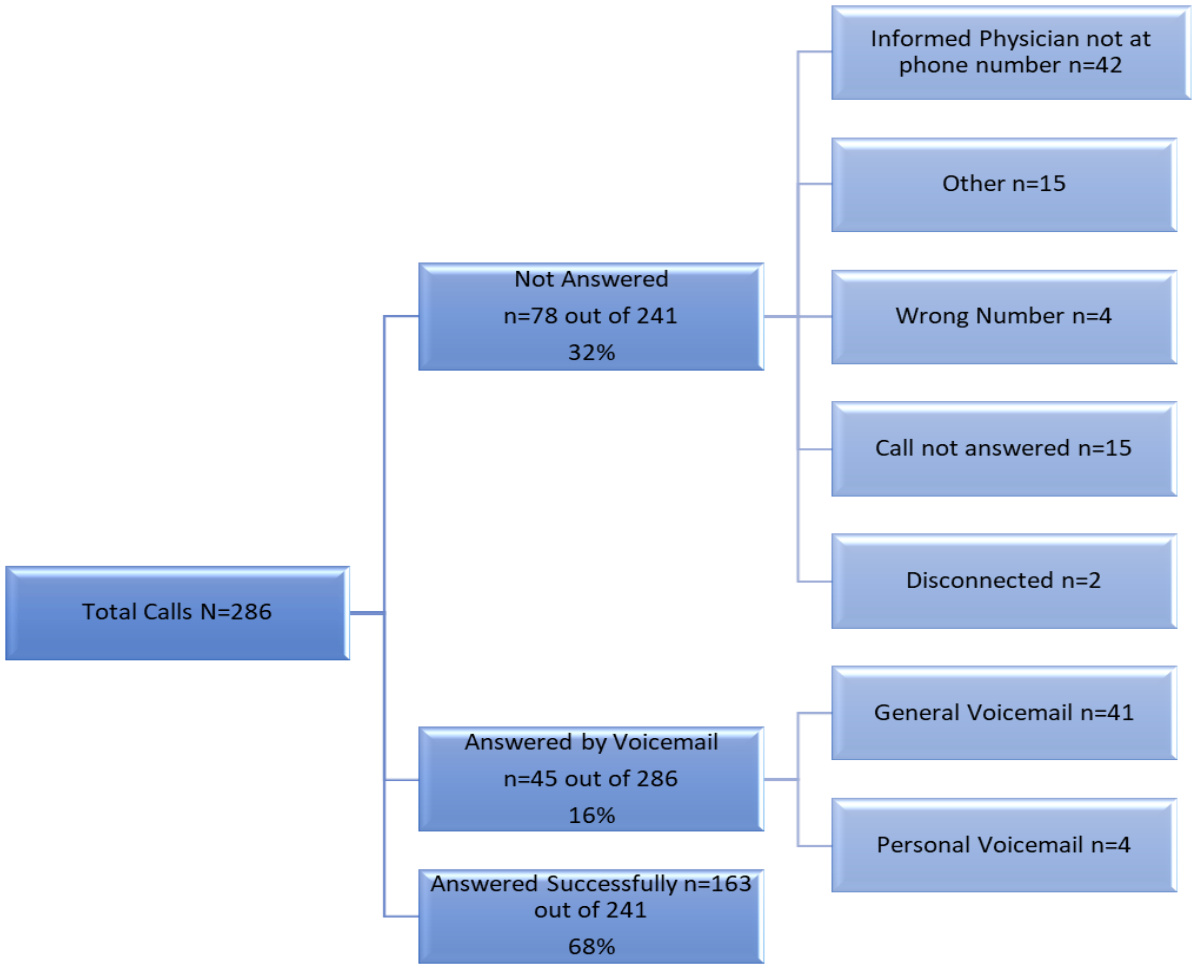
WellCare from which a population of 2,909 unique PCPs was identified. CCME randomly selected a sample of 286 providers from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding access that members have with contracted providers. The Telephonic Provider Access Study calls were answered successfully 68% of the time (163 out of 241) when omitting calls answered by personal or general voicemail messaging services. When compared to 2017 results of 60%, the 2018 study has a statistically significant increase in successful calls (p=.03) as shown in *Table 5: Telephone Access Study Answer Rate Comparison*.

Table 5: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact P-value
2017 Review	304	60%	<.03
2018 Review	286	68%	

Figure 3: Telephonic Provider Access Study Results provides an overview of the Telephone Provider Access Study Results.

Figure 3 Telephonic Provider Access Study Results



For calls not answered successfully (n=78 calls), 42 (54%) were unsuccessful because the provider was not at the office or phone number listed. Of the 163 successful calls, 149 of the 156 providers (96%) who responded to the question indicated they accept WellCare, although two (1%) indicated that this occurred only under certain conditions. Of 150 responses, 116 (77%) responded that they are accepting new Medicaid patients.

Regarding a screening process for new patients, 52 (45%) of the 115 providers that responded to the item indicated that an application or prescreen was necessary, with 21 (43%) indicating that an application must be filled out, whereas 14 (29%) require a review of medical records before accepting a new patient, and 6 (12%) required both. When the office was asked about the next available routine appointment, 77 (70%) of the 110 responses met contact requirements.

Figure 4: Provider Services Findings shows that 90% of the standards in Provider Services received a "Met" score.

Figure 4: Provider Services Findings

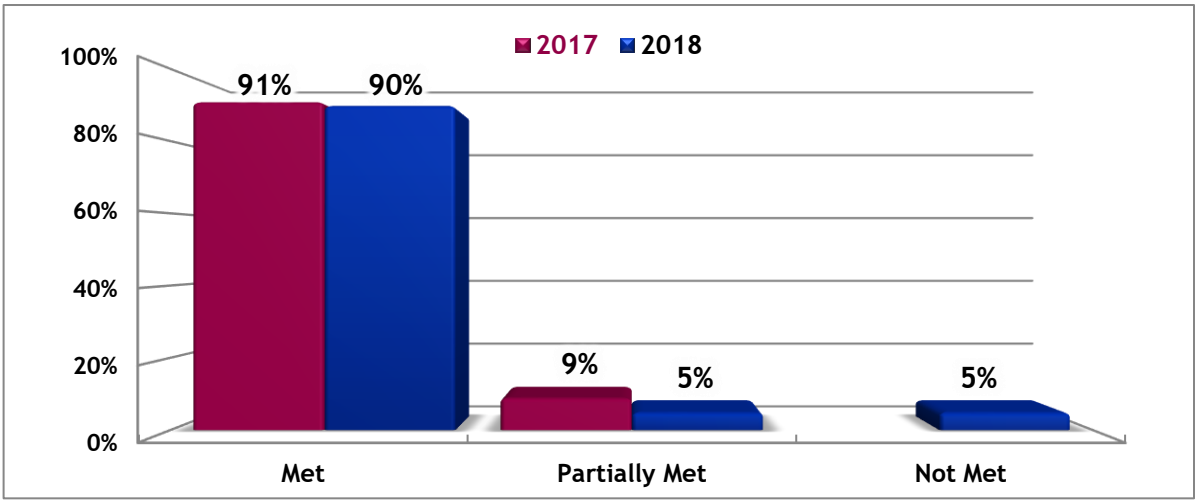


Table 6: Provider Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Credentialing and Recredentialing	Query of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List	Partially Met	Not Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Partially Met	Met
	Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List	Partially Met	Not Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Not Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Partially Met	Not Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Adequacy of the Provider Network	Members have a primary care physician located within a 30-mile radius of their residence	Met	Partially Met
Provider Education	The MCO formulates and acts within policies and procedures related to initial education of providers	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The *Telephonic Provider Access Study* conducted by CCME shows a statistically significant increase in success rate for calls made to provider offices.

Weaknesses

- *Policy SC22 OP-CR-001, Credentialing and Re-credentialing* has the following issues:
  - The policy does not include all the Program Integrity (PI) queries required by *SCDHHS*; the *Suspension List* and the *Behavioral Health Actions List* are missing.
  - The policy does not address whether WellCare is performing federal and state database checks for persons identified on ownership disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *SCDHHS Policy and Procedure Guide, Section 11.2*.
- *Policy SC22-OP-CR-024, Medicaid Eligibility Federal and State Sanctions and Opt Out* does not address the *SSDMF* or the following PI lists required by *SCDHHS*: *Suspension List* and the *Behavioral Health Actions List*.
- Credentialing and recredentialing files do not show evidence the following PI queries required by SCDHHS were performed: *Terminated for Cause List, Suspension List, and Behavioral Health Actions List*.
- *Policy SC22 OP-CR-009, SC - Assessment of Organizational Providers* does not address all the PI queries required by SCDHHS, such as the *Suspension List* and the *Behavioral Health Actions List*.
- *Policy SC22 OP-CR-046, Ongoing Monitoring of Providers* does not include the *SSDMF* even though onsite discussion confirmed the plan is querying the *SSDMF*. This was an issue in the previous EQR; WellCare submitted a corrected policy during the QIP review and the updated policy was never implemented.

- *Policy SC22 OP-CR-046, Ongoing Monitoring of Providers* does not include all the PI queries required by SCDHHS; the *Suspension List* and the *Behavioral Health Actions List* are missing.
- *Policy SC22 OP-NI-001, SC - GeoAccess Reporting* has a table of required network providers that includes the provider status code; however, this table is outdated.
- WellCare does not have a policy that describes its network evaluation process.
- *Policy SC22-GOV-PD-005, SC Cultural Competency* states that WellCare's full *Cultural Competency Plan* is posted to the website; however, CCME confirmed during the onsite visit that a full *Cultural Competency Plan* is not posted on the website.
- *Policy SC22 OP-NI-002, SC Provider Appointment and After-Hours Coverage* does not address the goal that providers must achieve to be considered in compliance with provider appointment and after-hours access standards.
- The South Carolina WellCare website has a training section for Medicaid providers. The *Provider Orientation* loaded to the website is for WellCare of Kentucky.

Quality Improvement Plans

- Update *Policy SC22 OP-CR-001, Credentialing and Re-credentialing* to include all PI queries required by SCDHHS.
- Update *Policy SC22-OP-CR-024, Medicaid Eligibility Federal and State Sanctions and Opt Out* to address queries of the *SSDMF*, *Suspension List* and the *Behavioral Health Actions List*.
- Implement a process to perform federal and state database checks for persons identified on ownership disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *SCDHHS Policy and Procedure Guide, Section 11.2*.
- Ensure credentialing and recredentialing files contain proof of all PI queries required by SCDHHS.
- Update *Policy SC22 OP-CR-009, SC - Assessment of Organizational Providers* to include all PI queries required by SCDHHS.
- Update *Policy SC22 OP-CR-046, Ongoing Monitoring of Providers*, to include the following queries: *SSDMF*, the *Suspension List*, and the *Behavioral Health Actions List*.
- Ensure *Policy SC22 OP-NI-001, SC - GeoAccess Reporting* is updated to include WellCare's current process for assessing compliance with the SCDHHS provider network requirements.
- Ensure WellCare has a policy that describes its provider network evaluation process.

- Update *Policy SC22 OP-NI-002, SC Provider Appointment and After-Hours Coverage* to address the goal that providers must achieve to be considered in compliance with provider appointment and after-hours access standards.
- Update the provider training website link to reflect the *South Carolina Provider Orientation* training document.

Recommendations

- Ensure *Policy SC22-GOV-PD-005, SC Cultural Competency* is updated to accurately address information regarding the *Cultural Competency Plan*.

C. Member Services

CCME's review of Member Services encompasses member rights; member education about the health plan, benefits, and services; enrollment and disenrollment; preventive health and chronic disease management education; the Member Satisfaction Survey; and grievances.

During onsite discussion about the timeframe WellCare has established to provide new member educational materials, CCME noted disagreement among WellCare staff; some stated the timeframe is within five business days of receipt of enrollment information, while others reported the timeframe as within 14 calendar days of receipt of enrollment information. Discrepancies in the timeframe to send new member materials are also found in several WellCare policies.

As of mid-year 2018, the *Member Handbook* is no longer mailed to new members. Instead, WellCare sends a *Quick Start Guide* that provides basic information about benefits, copayments, translation services, contact information, and a statement that members may obtain the full *Member Handbook* online or by contacting Member Services. CCME's review confirmed that plan policies do not reflect this change in process.

WellCare has engaged Teleperformance to provide Member Services call center functions. Local vendor oversight is conducted to ensure compliance with contractual obligations. The call center's automated system provides instructions for emergencies and allows callers to leave confidential voice messages. Additionally, an Interactive Voice Response system allows callers to perform specific functions, including but not limited to verifying eligibility/claim status. The Nurse Advice Line and the Behavioral Crisis Hotline are available to provide medical advice 24 hours a day via a toll-free telephone number.

The *Member Handbook* communicates information about recommended wellness and preventive health guidelines. Members are encouraged to obtain the recommended services in various ways, such as periodicity letters, mailed reminders, newsletters, and live and automated calls. WellCare provides incentives to members to obtain

recommended services by offering monetary rewards in the form of pre-paid gift cards. In addition, WellCare conducts and participates in community events to provide risk and wellness information to members and the public-at-large.

SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, is contracted by WellCare to conduct the annual Child and Adult surveys. The 2018 survey response rates increased for the Adult, Child, and Children with Chronic Conditions (CCC) surveys; however, all response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%. Appropriate processes are in place to analyze survey results and implement initiatives that address problematic areas. WellCare reported the 2018 CAHPS survey results to providers via the *Provider Newsletter*.

WellCare defines grievance processes and requirements in its *Medicaid Grievance Policy (SC22-OP-GR-001)*. Information about grievance requirements and processes are found in the *Member Handbook*, the *Provider Manual*, and on WellCare's website. Issues noted with documentation related to grievances include outdated grievance terminology, erroneous information that the *Appointment of Representative* form is available on the WellCare's website, and that members must be actively covered by WellCare in order to file a grievance. CCME also found inconsistencies in the timeframe to request a second-level grievance review and incomplete information related to extensions of grievance resolution timeframes.

Grievance files reflect that, in general, grievances are handled and resolved according to defined requirements. However, CCME notes a few isolated issues of concern. These include failure to fully investigate before closing a grievance, use of an acronym in a grievance resolution letter, and failure to include actions taken by another WellCare department to which a grievance was referred.

WellCare's process, as stated in policy and during the onsite visit, is to report grievance data quarterly to various committees, including the Utilization Management Advisory Committee (UMAC). UMAC meeting minutes do not provide evidence this process is followed consistently. Additionally, the *2018 Quality Improvement Work Plan* has not been updated with grievance data.

As noted in *Figure 5: Member Services Findings*, WellCare achieved scores of "Met" for 88% of the Member Services standards. This represents a decrease of three percent from the 2017 review. Scores of "Partially Met" are related to member education and grievances.

Figure 5: Member Services Findings

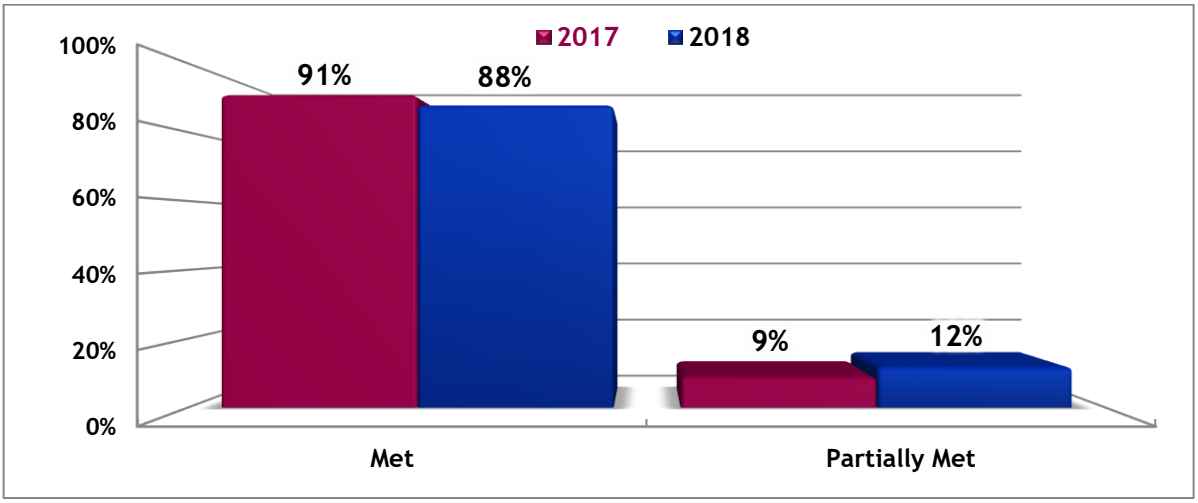


Table 7: Member Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Member MCO Program Education	Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information	Met	Partially Met
	Members are informed in writing of changes in benefits and changes to the provider network	Met	Partially Met
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to the definition of a grievance and who may file a grievance	Met	Partially Met
	Procedures for filing and handling a grievance	Partially Met	Met
	Timeliness guidelines for resolution of a grievance	Partially Met	Met
	The MCO applies grievance policies and procedures as formulated	Partially Met	Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Grievances	Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- A glossary of terms in the *Member Handbook* enhances member understanding of the information presented in the handbook.
- The *Member Handbook* provides an example of the WellCare Member ID Card to illustrate the contents of the card.

Weaknesses

- Policies *SC22-OP-EN-001, New Member Materials* and *SC22-HS-QI-012 South Carolina - Early Periodic Screening Diagnosis and Treatment (EPSDT)* contain discrepancies in the timeframes to send new member materials. When discussing the timeframe for sending educational materials to new members, disagreement was noted among WellCare staff.
- WellCare policies do not reflect the change in process of sending a *Quick Start Guide* to new members instead of a *Member Handbook*.
- Requirements for obtaining second opinions on page 38 of the *Member Handbook* do not indicate clearly that prior approval from the health plan is required to obtain a second opinion at no cost from an out-of-network provider.
- *Policy SC22-PD-002, Covered Service Policy* states WellCare will notify members at least 30 days prior to discontinuation or modification of approved additional services but does not address notification to members of changes in core benefits and services.
- CAHPS survey response rates for the Child survey increased to 18.5%. The Adult survey response rate increased to 22.5%, and the Children with Chronic Conditions response rates increased to 16.0%. All response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.
- *Policy SC22-OP-GR-001* incorrectly defines a grievance as "an expression of dissatisfaction about any matter other than an action." The current terminology is "adverse benefit determination" rather than "action," as specified in *42 CFR §438.400 (b)* and *the SCDHHS Contract, Section 9.1 (a)*.

- Page 63 of the *Member Handbook* states the *Appointment of Representative* form is available on the website at www.wellcare.com/South-Carolina. A search of the website does not result in finding the form on the Medicaid section of the site.
- Page 98 of the *Provider Manual* states members may file grievances "at any time after the date of the dissatisfaction and during the period in which the Member has active coverage by WellCare." The requirement that grievances must be filed "during the period in which the Member has active coverage by WellCare" is not stated in *Policy SC22-OP-GR-001*, the *Member Handbook*, or on the website; and no restrictions are defined in the *SCDHHS Contract* and *42 CFR §438 Subpart F—Grievance and Appeal System* which limit grievances to current enrollees only.
- The *Grievance Resolution Letter* template states a second-level grievance review must be requested within 30 calendar days of the date of the letter. This 30-day timeframe for requesting a second-level grievance review is not stated in *Policy SC22-OP-GR-001*, the *Member Handbook*, the *Provider Manual*, or on the website.
- Page six of *Policy SC22-OP-GR-001* states, "If a grievance decision is extended, the plan must provide written notification and the reason for the delay." This applies only to extensions requested by the health plan.
- *Policy SC22-OP-GR-001* does not include that the health plan must make reasonable attempts to provide oral notice of an extension of the grievance resolution timeframe or that the written notice of the extension must be provided within two calendar days.
- Page 64 of the *Member Handbook* addresses written notification of a plan-requested extension but does not address the requirement of an attempted oral notification.
- Issues of concern noted in grievance files include:
  - One grievance was not fully investigated before closing the grievance and sending resolution to the member.
  - One resolution letter used an acronym that the member may not understand multiple times without defining the acronym.
  - One file indicated the grievance was referred to another WellCare department to assist with resolution but contained no documentation of actions taken by that department.
  - Numerous instances of grammatical errors exist in grievance resolution letters.
- Issues noted related to grievance reporting include:
  - Utilization Management Advisory Committee minutes do not reflect consistent grievance reporting despite documentation in *Policy SC22-OP-GR-001* which states grievance data is reported to the Medical Advisory Committee and onsite confirmation that grievance information is reported to this committee quarterly. CCME's review of UMAC meeting minutes confirmed grievance data and information

was reported in only two of six quarterly meetings between August 10, 2017 and November 12, 2018. Minutes from three of the meetings contained a statement that "the grievances report was not submitted…"

- The "Grievances" tab of the *2018 Quality Improvement Work Plan* indicates grievance data is "unavailable" for 2017, and quarters one and two of 2018.

Quality Improvement Plans

- Determine the timeframe of sending member educational materials to new members and revise any applicable documents, policies, etc. with the timeframe.
- Update all applicable documents to reflect the new process of sending a *Quick Start Guide* in lieu of the *Member Handbook*. Revise documents to reflect that members are informed that they may obtain a *Member Handbook* online or by contacting Member Services.
- Revise *Policy SC22-PD-002* to include processes to notify members of changes to core benefits/services.
- Revise the definition of a grievance in *Policy SC22-OP-GR-001* to include current terminology as specified in *42 CFR §438.400 (b)* and the *SCDHHS Contract, Section 9.1 (a)*.
- Update WellCare's Medicaid website to include the *Appointment of Representative* form.
- Ensure grievance data is reported to the Utilization Management Advisory Committee, as stated in *Policy SC22-OP-GR-001*.
- Ensure the *Quality Improvement Work Plan* is routinely updated to include quarterly grievance data.

Recommendations

- Clearly indicate on page 38 of the *Member Handbook* that prior approval from the health plan is required to obtain a second opinion at no cost from an out-of-network provider.
- Continue working with vendor to increase CAHPS survey response rates. Consider options such as adding reminders to the call center and maximizing oversampling to increase response rates.
- Remove the statement on page 98 of the *Provider Manual* that indicates members must be actively covered by WellCare to file a grievance.
- Update *Policy SC22-OP-GR-001*, the *Member Handbook*, the *Provider Manual*, and the website to include the filing timeframe for a second-level grievance review.

- Revise *Policy SC22-OP-GR-001* to indicate member notification of an extension is required only when the plan requests the extension.
- Ensure *Policy 22-OP-GR-001* and the *Member Handbook* include the timeframe for written notification of a health plan-requested extension and that the health plan must make reasonable attempts to provide oral notice of the extension in addition to the written notification.
- Ensure grievance staff thoroughly investigate the issues within the grievance prior to closing the file.
- When grievances are referred to another WellCare department, ensure all actions taken by that department to resolve the grievance are documented within the grievance file.
- Avoid using acronyms that members may not understand in grievance resolution letters.
- Implement a process to review grievance resolution letters for grammatical and syntax errors prior to mailing.

D. Quality Improvement

For the Quality Improvement (QI) section, CCME reviewed the *2018 Medicaid Quality Improvement Program Description*, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluation. WellCare's *2018 Medicaid Quality Improvement Program Description* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The Board of Directors provides strategic direction and ultimate authority for the QI Program. This board has delegated the operational responsibility for the program to WellCare's Director of Quality with support from the corporate QI Department and the Senior Medical Director.

The Quality Improvement Committee (QIC) provides oversight and approval for all QI activities. The Utilization Management Advisory Committee (UMAC) oversees all clinical QI, utilization management, and behavioral health activities. The primary responsibilities for both committees are outlined in the QI Program Description.

Monitoring provider compliance with preventive health and clinical practice guidelines is an objective for the QI Program Description. The *2018 QI Work Plan* addresses the monitoring of compliance against the guidelines; however, the specific guidelines monitored are not addressed, and the monitoring frequency is listed as quarterly yet "N/A" is recorded for the first, second, and third quarters. *Policy SC22-HS-QI-009, Provider Clinical Practice Guidelines and Preventive Health Guidelines* indicate monitoring is conducted annually. CCME confirmed during the onsite visit that monitoring

is conducted annually, and that Dilated Retinal Exams and Attention-Deficit/Hyperactivity Disorder were monitored.

WellCare evaluates the effectiveness of their QI Program annually. For this review the health plan provided the *2017 Medicaid Quality Improvement Program Evaluation*. This report provides an assessment of the of the results of the QI activities conducted during 2017. Some of the reported results appear incomplete or incorrect.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

WellCare uses Inovalon's Quality Spectrum Insight, a certified software application, for HEDIS measure calculation. The comparison from the previous to the current year reveals a strong increase (>10%) in several measures including Combination 1 Immunizations, Lead Screening, and Medication Management for People with Asthma. One measure, Persistence of Beta-Blocker Treatment After a Heart Attack, shows a substantial (>10%) decrease in the reported rate. The 2018 rate, the 2017 rate, and the change in rate are presented in *Table 8: HEDIS Performance Measure Data*.

Table 8: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	78.83%	86.46%	7.63%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	72.45%	72.99%	0.54%
Counseling for Nutrition	55.32%	59.61%	4.29%
Counseling for Physical Activity	43.98%	50.85%	6.87%
Childhood Immunization Status (cis)			
DTaP	71.53%	69.83%	-1.70%
IPV	87.04%	86.13%	-0.91%
MMR	88.89%	88.08%	-0.81%
HiB	82.41%	81.02%	-1.39%
Hepatitis B	86.34%	87.10%	0.76%
VZV	88.66%	87.35%	-1.31%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Pneumococcal Conjugate	74.77%	72.51%	-2.26%
Hepatitis A	84.26%	83.70%	-0.56%
Rotavirus	68.52%	70.07%	1.55%
Influenza	31.48%	37.23%	5.75%
Combination #2	67.13%	67.64%	0.51%
Combination #3	64.81%	65.21%	0.40%
Combination #4	62.27%	63.75%	1.48%
Combination #5	53.70%	56.93%	3.23%
Combination #6	26.62%	32.36%	5.74%
Combination #7	51.62%	55.47%	3.85%
Combination #8	25.93%	31.87%	5.94%
Combination #9	23.38%	28.71%	5.33%
Combination #10	22.69%	28.22%	5.53%
Immunizations for Adolescents (ima)			
Meningococcal	66.67%	63.50%	-3.17%
Tdap/Td	82.18%	78.59%	-3.59%
Combination #1	12.27%	24.82%	12.55%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	66.20%	62.53%	-3.67%
Lead Screening in Children (lsc)	11.81%	23.36%	11.55%
Breast Cancer Screening (bcs)	72.22%	66.27%	-5.95%
Cervical Cancer Screening (ccs)	53.53%	53.68%	0.15%
Chlamydia Screening in Women (chl)			
16-20 Years	54.60%	58.09%	3.49%
21-24 Years	69.85%	66.06%	-3.79%
Total	59.02%	60.36%	1.34%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	78.74%	82.93%	4.19%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.28%	30.07%	-0.21%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	50.36%	61.51%	11.15%
Bronchodilator	79.47%	77.82%	-1.65%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	48.61%	56.61%	8.00%
5-11 Years - Medication Compliance 75%	20.74%	25.86%	5.12%
12-18 Years - Medication Compliance 50%	43.98%	47.26%	3.28%
12-18 Years - Medication Compliance 75%	12.65%	22.89%	10.24%
19-50 Years - Medication Compliance 50%	55.70%	48.39%	-7.31%
19-50 Years - Medication Compliance 75%	16.46%	24.73%	8.27%
51-64 Years - Medication Compliance 50%	46.67%	53.13%	6.46%
51-64 Years - Medication Compliance 75%	20.00%	37.50%	17.50%
Total - Medication Compliance 50%	48.20%	52.52%	4.32%
Total - Medication Compliance 75%	17.84%	25.37%	7.53%
Asthma Medication Ratio (amr)			
5-11 Years	70.34%	75.33%	4.99%
12-18 Years	58.29%	61.40%	3.11%
19-50 Years	42.06%	47.86%	5.80%
51-64 Years	52.38%	60.47%	8.09%
Total	61.82%	66.19%	4.37%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	39.02%	46.72%	7.70%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	76.92%	62.50%	-14.42%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	69.92%	68.29%	-1.63%
Statin Adherence 80% - 21-75 years (Male)	37.21%	44.05%	6.84%
Received Statin Therapy - 40-75 years (Female)	72.90%	73.04%	0.14%
Statin Adherence 80% - 40-75 years (Female)	30.77%	32.14%	1.37%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Received Statin Therapy - Total	71.30%	70.59%	-0.71%
Statin Adherence 80% - Total	34.15%	38.10%	3.95%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	84.84%	88.08%	3.24%
HbA1c Poor Control (>9.0%)	48.64%	46.96%	-1.68%
HbA1c Control (<8.0%)	41.40%	44.04%	2.64%
HbA1c Control (<7.0%)	NA	NA	NA
Eye Exam (Retinal) Performed	39.14%	41.36%	2.22%
Medical Attention for Nephropathy	92.53%	92.70%	0.17%
Blood Pressure Control (<140/90 mm Hg)	43.44%	55.23%	11.79%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	58.52%	59.03%	0.51%
Statin Adherence 80%	41.76%	38.82%	-2.94%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	71.67%	71.88%	0.21%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	37.27%	40.06%	2.79%
Effective Continuation Phase Treatment	24.91%	26.42%	1.51%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	42.41%	49.86%	7.45%
Continuation and Maintenance (C&M) Phase	56.36%	62.88%	6.52%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	49.62%	58.41%	8.79%
7-Day Follow-Up	28.46%	35.58%	7.12%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
30-Day Follow-Up	53.07%	50.90%	-2.17%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
7-Day Follow-Up	37.63%	37.11%	-0.52%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
*30-Day Follow-Up: 13-17 Years**	6.67%	4.00%	-2.67%
*7-Day Follow-Up: 13-17 Years**	6.67%	4.00%	-2.67%
30-Day Follow-Up: 18+ Years	11.60%	14.53%	2.93%
7-Day Follow-Up: 18+ Years	7.84%	10.06%	2.22%
30-Day Follow-Up: Total	11.38%	13.84%	2.46%
7-Day Follow-Up: Total	7.78%	9.66%	1.88%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75.10%	72.07%	-3.03%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	69.75%	65.84%	-3.91%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	71.43%	75.00%	3.57%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	63.17%	63.65%	0.48%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	NA	0.00%	NA
6-11 Years	14.89%	6.78%	-8.11%
12-17 Years	25.32%	23.33%	-1.99%
Total	20.77%	16.67%	-4.10%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	87.82%	88.47%	0.65%
Digoxin	52.94%	NR	NA
Diuretics	89.92%	88.35%	-1.57%
Total	88.52%	88.42%	-0.10%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.76%	1.32%	-0.44%
Appropriate Treatment for Children With URI (uri)	87.52%	87.45%	-0.07%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	27.01%	31.71%	4.70%
Use of Imaging Studies for Low Back Pain (lbp)	68.13%	64.76%	-3.37%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
*1-5 Years**	NA	NA	NA
6-11 Years	0.00%	0.00%	0.00%
12-17 Years	0.00%	1.61%	1.61%
Total	0.00%	0.97%	0.97%
Use of Opioids at High Dosage (uod)	NA	50.46	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	NA	264.51	NA
Multiple Pharmacies	NA	74.05	NA
Multiple Prescribers and Multiple Pharmacies	NA	40.23	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	76.48%	72.70%	-3.78%
45-64 Years	84.92%	84.32%	-0.60%
*65+ Years**	100.00%	66.67%	-33.33%
Total	79.27%	76.69%	-2.58%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	95.23%	95.23%	0.00%
25 Months - 6 Years	83.50%	82.31%	-1.19%
7-11 Years	86.43%	88.64%	2.21%
12-19 Years	83.58%	85.81%	2.23%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**		14.29%	NA
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**		7.14%	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**			NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**			NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years		32.65%	NA
Other drug abuse or dependence: Engagement of AOD		21.43%	NA

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Treatment: 13-17 Years			
Initiation of AOD Treatment: 13-17 Years	33.33%	30.84%	-2.49%
Engagement of AOD Treatment: 13-17 Years	17.20%	19.63%	2.43%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years		44.50%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years		10.53%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years		54.37%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years		14.56%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years		44.64%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years		10.97%	NA
Initiation of AOD Treatment: 18+ Years	38.89%	44.22%	5.33%
Engagement of AOD Treatment: 18+ Years	7.94%	11.13%	3.19%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total		43.85%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total		10.46%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: Total		54.37%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: Total		14.56%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total		43.34%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total		12.10%	NA
Initiation of AOD Treatment: Total	38.51%	43.28%	4.77%
Engagement of AOD Treatment: Total	8.57%	11.73%	3.16%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	91.73%	89.76%	-1.97%
Postpartum Care	66.93%	64.96%	-1.97%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	33.33%	100.00%	66.67%
6-11 Years	54.84%	45.16%	-9.68%
12-17 Years	39.39%	52.94%	13.55%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Total	46.27%	50.60%	4.33%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	0.52%	NA	NA
21-40 Percent	3.10%	NA	NA
41-60 Percent	5.17%	NA	NA
61-80 Percent	11.63%	NA	NA
81+ Percent	79.59%	NA	NA
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.62%	2.26%	0.64%
1 Visit	1.62%	2.01%	0.39%
2 Visits	2.31%	2.76%	0.45%
3 Visits	5.32%	6.03%	0.71%
4 Visits	8.80%	7.04%	-1.76%
5 Visits	20.83%	14.32%	-6.51%
6+ Visits	59.49%	65.58%	6.09%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	58.96%	57.86%	-1.10%
Adolescent Well-Care Visits (awc)	41.67%	53.04%	11.37%

Note. * indicates small denominator; NR= not reported; NA= not applicable

WellCare reports 12 quality clinical withhold measures for 2017. As per the *SCDHHS Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile=1 point; 10-24 %=2 points; 25-49=3 points; 50-74 % = 4 points; 75-90 % = 5 points; >90 % 6 points). Points attained for each measure are multiplied by individual measure weights then summed to obtain the quality index score. The 2017 rate, percentile, point value, and index score are shown in *Table 9: Quality Withhold Measures*. The Diabetes measure rates generate the highest index score, followed by Women's Health, and Pediatric Preventive Care.

Table 9: Quality Withhold Measures

Measure	2017 Rate	2017 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	88.08%	75	5.00	4.25
HbA1c Control (< =9)	53.04%	50	4.00	
Eye Exam (Retinal) Performed	41.36%	10	2.00	
Medical Attention for Nephropathy	92.70%	75	5.00	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	89.76%	75	5.00	4
Breast Cancer Screen	53.68%	25	3.00	
Cervical Cancer Screen	55.04%	25	3.00	
Chlamydia Screen in Women (Total)	60.36%	50	4.00	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	65.58%	50	4.00	3
Well Child Visits in 3rd,4th,5th&6th Years of Life	57.86%	<10	1.00	
Adolescent Well-Care Visits	53.04%	50	4.00	
Weight Assessment/Adolescents: BMI % Total	72.99%	25	3.00	

Performance Improvement Project Validation

Validation of the Performance Improvement Projects (PIPs) is in accordance with the CMS protocol *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Three projects were submitted and validated using the *CMS Protocol for Validation of Performance Improvement Projects*. The projects were Improving Dilated Retinal Exam (DRE) Screening, Access to Care, and Improving Hemoglobin A1C Testing. The three projects received a validation score within the High Confidence range. *Table 10: Performance Improvement Project Validation Scores* provides an overview of each project's validation score.

TABLE 10: Performance Improvement Project Validation Scores

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Improving Dilated Retinal Exam (DRE) Screening	Not Validated	78/78=100% High Confidence in Reported Results
Access to Care	78/78=100% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results
Improving Hemoglobin A1C Testing	91/91=100% High Confidence in Reported Results	90/91=99% High Confidence in Reported Results

CCME identified documentation errors in the Access to Care and Improving Hemoglobin A1C Testing project. The recommendations for correcting these errors are displayed in *Table 11: Performance Improvement Project Errors and Recommendations*.

TABLE 11: Performance Improvement Project Errors and Recommendations

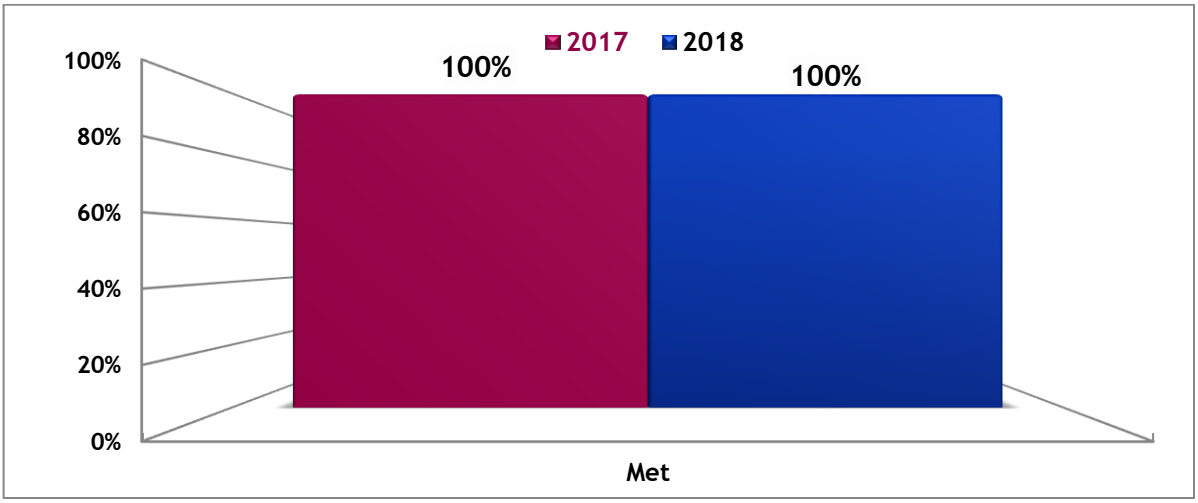
Section	Reasoning	Recommendation
Access to Care		
Was there any documented, quantitative improvement in processes or outcomes of care?	AAP rate decreased from baseline to follow-up.	Continue ongoing member, provider, and plan interventions to improve rate.
Improving Hemoglobin A1C Testing		

Section	Reasoning	Recommendation
Is there any statistical evidence that any observed performance improvement is true improvement?	Statistical significance is not required when using the entire population. For the test comparing 2015 and 2016 rates, the numerator and denominator for Fisher's test do not match numbers in results Table for 2015/2016 comparison.	Adjust values so that chi square, z-test, or Fisher's exact tests contain same values as reported values for 2016 and 2016.

Details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

WellCare continues to meet all the standards in the Quality Improvement section as shown in *Figure 6: Quality Improvement Findings*.

Figure 6: Quality Improvement Findings



Strengths

- Plan uses a certified software application for HEDIS calculations.
- All PIPs scored within the High Confidence range and meet all the CMS Validation requirements.

Weaknesses

- The *2018 QI Workplan* indicates the monitoring of provider compliance with the clinical practice and preventive health guidelines is quarterly and does not include the specific guidelines monitored.

- Some of the reported results in the *2017 Medicaid Quality Improvement Program Evaluation* appear incomplete or incorrect.

Recommendations

- Update the *2018 QI Workplan* to reflect the specific guidelines monitored and monitoring frequency for provider compliance with the clinical practice and preventive health guidelines.
- When determining the effectiveness of the QI activities, include the results of all activities. If the results are incomplete, make a notation in the analysis documentation.

E. Utilization Management

WellCare's *Utilization Management Program Description* outlines and describes the Utilization Management (UM) Program for physical and behavioral health. UM policies and procedures define how UM, medical necessity determinations, appeals, and Care Management (CM) services are operationalized to provide services to members. CVS Caremark™, the pharmacy benefit manager, coordinates decisions for drug coverage. The Senior Medical Director, Dr. Robert London, oversees UM activities.

UM approval and denial files confirm timely determinations and indicate decisions are aligned with policies. Several appeal files reflect untimely determinations due to beginning the resolution timeframe for a member appeal request when written documentation is received. CCME found that *Policy SC22-RX-012, Pharmacy Appeals* reflects incorrect terminology of "adverse coverage determination" and "redetermination" that is not consistent with *SCDHHS Contract* terminology.

In October 2017, WellCare integrated the Disease Management (DM) and CM programs to establish a Care Management Population Health model that provides a framework for CM and DM programs using a holistic approach. Case management files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Documents such as the *Utilization Management Program Evaluation* and UMAC meeting minutes indicates WellCare monitors and analyzes under- and over-utilization of medical services as required by the contract.

CCME's review of the program reveals CM staff use a multi-disciplinary approach to incorporate physical health, behavioral health, and pharmaceutical needs during decision making and when providing service. CCME identified weaknesses and provides recommendations to address them in this document.

Overall, the UM Program follows requirements described in the *SCDHHS Contract* and the *Code of Federal Regulations*.

Figure 7: Utilization Management Findings shows that 96% of the standards in the Utilization Management section received a "Met" score.

Figure 7: Utilization Management Findings

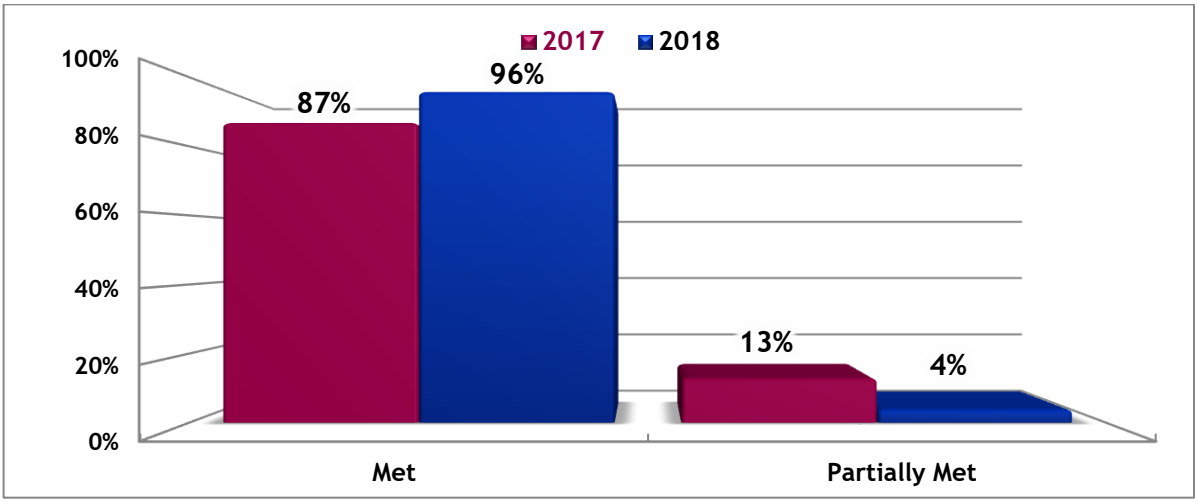


TABLE 12: Utilization Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Medical Necessity Determinations	Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Partially Met	Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Partially Met	Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met
Appeals	The MCO applies the appeal policies and procedures as formulated	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- UM policies provide detailed descriptions of roles, responsibilities, and UM staff credentials.
- Care Managers provide care plans to member and providers.
- Identified HEDIS care gaps are communicated to providers immediately with instructions about how to address them.

Weaknesses

- Page 36 in the *Member Handbook* incorrectly references the timeframe for member-requested extensions of expedited authorization determinations as up to 48 hours. However, the *SCDHHS Contract, Section 8.6.2.3* allows 14 calendar days for member-requested extensions.
- *Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services* does not address the requirement in *SCDHHS Contract, Section 4.2.11.2.7*.
- Throughout *Policy SC22-RX-012, Pharmacy Appeals* the term "adverse benefit determination" is referred to as "adverse coverage determination" and the term "appeal" is referred to as "redetermination" and the respective terms are used interchangeably.
- An *Appointment of Representative* (AOR) form is not available on the website for providers to file an appeal on behalf of the member as directed on page 93 in the *Provider Manual*.
- Page 10, item VI (2) of *Policy SC22-RX-012, Pharmacy Appeals* states member notification of the appeal decision is provided by mail "within the time frame" but does not specify the timeframe for member notification.
- A few of the appeal files were resolved outside of the resolution timeframe.

Quality Improvement Plan

- Revise page 36 in the *Member Handbook* to indicate expedited service authorizations can be extended up to 14 calendar days when requested by a member.
- Ensure staff is following the required timeframes for processing appeals, as required in *SCDHHS Contract, Section 9.1.4.4.1* and according to *Policy SC22-HS-AP-002, Member Appeals*.

Recommendations

- Revise *Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services* to include the requirements specified in the *SCDHHS Contract, Section 4.2.11.2.7*.
- Revise Policy SC22-RX-012, Pharmacy Appeals to use current SCDHHS Contract terminology of "adverse benefit determination" instead of "adverse coverage determination" and use "appeal" instead of "redetermination."
- Update the website to include the AOR form.
- Edit page 10, section VI (2) in *Policy SC22-RX-012, Pharmacy Appeals,* to indicate member notification of an appeal decision is provided within the timeframes referenced on page 19, item 4 of the policy. Additionally, update page 19 to reflect the determination timeframe includes member notification of the decision.

F. Delegation

WellCare's delegated organizations have written, signed agreements designating the delegated activities, including compliance and oversight requirements; addendums define any State specific contract requirements.

WellCare's delegated services are defined in *Table 13: Delegated Entities and Services*.

Table 13: Delegated Entities and Services

Service	Delegated Entities
UM	Advanced Medical Review; CareCore National, LLC d/b/a EviCore Healthcare; Health Help, LLC; Progeny Health, Inc.
UM	Behavioral Health - Focus Health
Nurse Advice Line	CareNet
Pharmacy	CVS
Customer Service	Teleperformance; The Results Companies; SPH Analytics

Service	Delegated Entities
Crisis Line	Health Integrated, Inc.
Case Management	Alere
Vision	March Vision
Credentialing	AU Medical Center; Greenville Hospital System; Integra Partners, IPA; Linkia, LLC; Mary Black HealthNetwork Inc.; Medical University Hospital Authority; Minute Clinic; Preferred Care of Aiken, Inc.; Regional Health Plus LLC; Roper St. Francis Healthcare (CareAlliance Health Services); St. Francis Physician Services; Take Care Clinics; United Physicians, Inc. (formerly Provider Healthlink of South Carolina, LLC); Drynachan LLC (DBA Advance Health); OptumHealth Care Solutions; Palmetto Health University of South Carolina Medical Group; Take Care Clinics; University Health Link

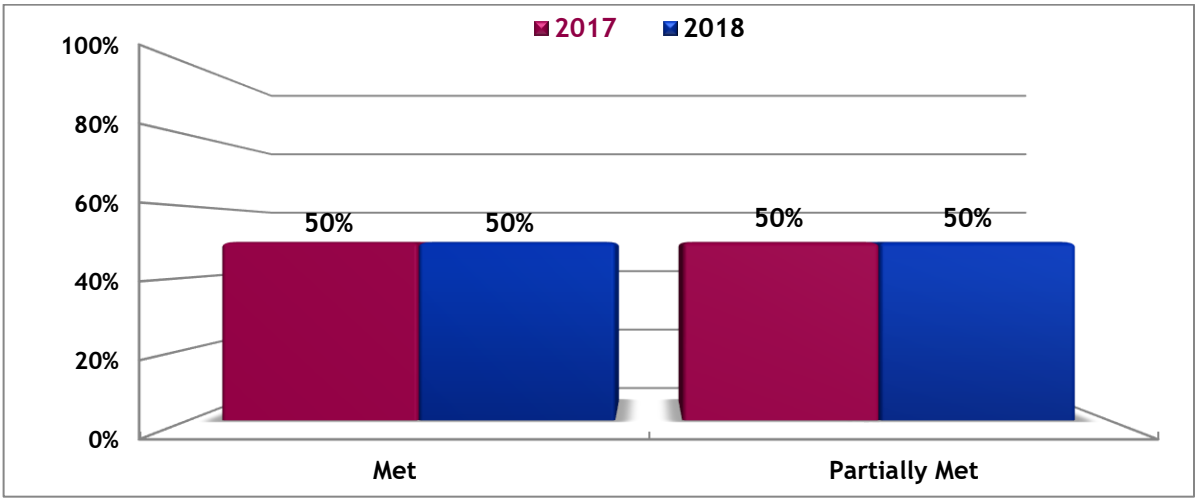
Policy SC22-CP-AO-007, Delegation Oversight and *SC22-CP-AO-007-PR-001, Delegation Oversight Procedure* define the functions and processes for oversight of delegated activities. Both the policy and procedure have incorrect references to renamed credentialing policies. Revised copies were presented at the onsite and will be considered during the Quality Improvement Plan review process.

CCME received proof of annual or pre-delegation oversight activities for all delegated entities. WellCare's oversight process includes pre-delegation oversight for entities that are under consideration for delegation, annual oversight for current delegates, and monthly and/or quarterly data review with corrective action, as appropriate. CCME confirmed during onsite visit discussions that as a result of the 2017 EQR findings, WellCare provided training to ensure the WellCare employees conducting delegation oversight are aware of South Carolina requirements and are consistent in documenting review findings across the reviewed entities. Improvement is noted in this EQR; however, a few of the entities show "N/A" for the *Ownership Disclosure Form* standard for the credentialing/recredentialing file reviews. WellCare provided evidence that focused reviews were performed to obtain the information after the audit.

The credentialing/recredentialing review form does not address all of the Program Integrity (PI) queries that are required by SCDHHS: *Termination for Cause List*, *Suspension List*, and *Behavioral Health Actions List*.

Figure 8: Delegation Findings shows that one standard in Delegation received a "Met" score and the other standard received a "Partially Met" score.

Figure 8: Delegation Findings



Weaknesses

- *Policy SC22-CP-AO-007, Delegation Oversight* and *SC22-CP-AO-007-PR-001, Delegation Oversight Procedure* have incorrect references to renamed credentialing policies.
- For the credentialing/recredentialing file review oversight, a few of the entities showed "N/A" for the *Ownership Disclosure Form* standard. WellCare showed evidence that focused reviews were performed to obtain the information after the audit.
- The credentialing/recredentialing oversight file review form does not address all PI queries that are required by *SCDHHS: Termination for Cause List, Suspension List,* and *Behavioral Health Actions List*.

Quality Improvement Plans

- Update *Policy SC22-CP-AO-007, Delegation Oversight* and *SC22-CP-AO-007-PR-001, Delegation Oversight Procedure* to include the correct references to the credentialing policies.
- Update the credentialing/recredentialing file oversight review form to reflect all the PI queries required by *SCDHHS*.

Recommendations

- Ensure *Ownership Disclosure Forms* are properly addressed during the delegated entity oversight review for credentialing/recredentialing.

G. State Mandated Services

WellCare ensures Early and Periodic Screening Diagnostic and Treatment (EPSDT) services for members through the month of their 21st birthday and has several processes in place

to notify and remind providers of needed EPSDT services. These tools include sending monthly membership lists of missed or upcoming services, the *EPSDT Tool Kit*, and the *Provider Manual*. The plan monitors provider compliance with provision of EPSDT services and required immunizations through medical record reviews conducted by the WellCare Quality Improvement Department. WellCare provides all core benefits specified by the *SCDHHS Contract*. A Quality Improvement Plan item from the 2017 EQR relating to credentialing was not implemented.

Figure 9: State Mandated Services

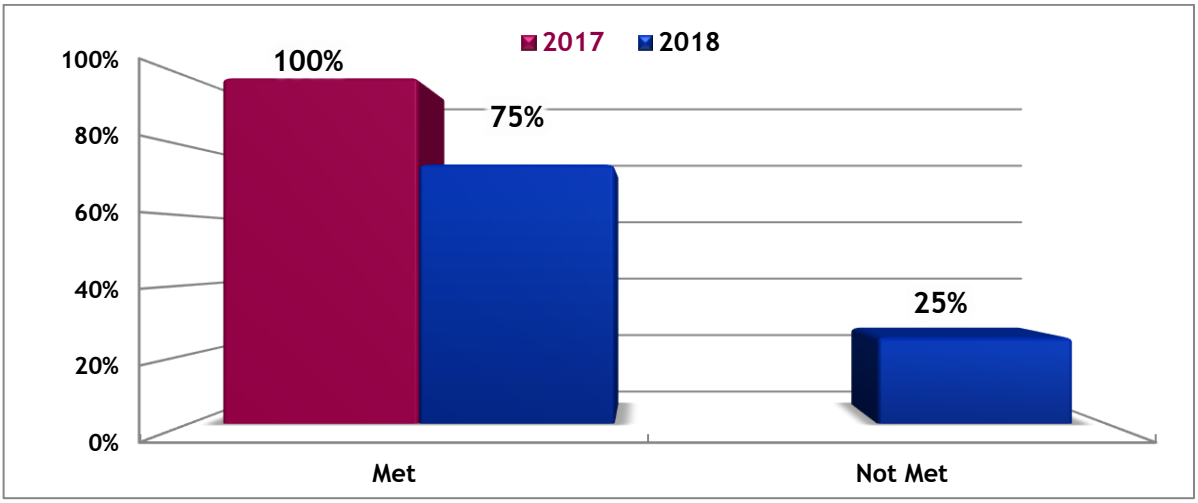


TABLE 14: State Mandated Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
State Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Weaknesses

- The *Provider Manual* does not list newborn hearing screenings as a Core Benefit to newborns in an inpatient hospital setting.
- WellCare has an outstanding deficiency from the 2017 External Quality Review related to querying the *Social Security Death Master File*.

Quality Improvement Plans

- Ensure that all deficiencies identified in the EQR are corrected.

Recommendations

- Update the *Provider Manual* to include the Core Benefit requirement for newborn hearing screenings in inpatient hospital settings.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

October 22, 2018

Ms. Sonya Nelson
Interim Plan President
WellCare of South Carolina
200 Center Point, Suite 180
Columbia, SC 29210

Dear Ms. Nelson:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2018 External Quality Review (EQR) of WellCare Of South Carolina is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **December 11th and 12th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **November 5, 2018.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2017 and 2018.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results

for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from October 2017 through October 2018. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of October 2017 through October 2018.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    c. reporting frequency and format;
    d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    f. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    g. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    h. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of November 2017 through October 2018. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of November 2017 through October 2018, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

    Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.

2. Results of the Preventative Health and Clinical Practice guidelines monitoring.

3. Several credentialing and/or recredentialing files were missing information or need explanation. See attached list.

4. Copy of most recent Deficiency Detail Report mentioned in Policy SC22 OP-NI-001, South Carolina-GeoAccess Reporting.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**WellCare**
Name of PIP:	**IMPROVING HEMOGLOBIN A1C TESTING - Clinical**
Reporting Year:	**2016-2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Analysis of data regarding enrollee care.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This addresses a key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is stated in document on page 3.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicator measures changes in health status and processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	A clear definition of enrollees to whom the study question is relevant is documented.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data collection approach captured all enrollees to whom the study measure applied.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or*	**NA**	Sampling not used.

Component / Standard (Total Points)	Score	Comments
census used:		
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data source is identified as Administrative Data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Programmed pull from claims/encounter files of all eligible members.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	There is consistent data collection using program pulled data.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The data analysis plan is specified as once per year.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel involved with study is provided in Attachment A.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Several interventions were implemented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis of findings is performed according to the data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and one repeat measurement are identified.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis included interpretation of success and continued action plans.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Measurement has two re-measurements.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvement from baseline is documented.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement has face validity.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**PARTIALLY MET**	Statistical significance is not required when using the entire

Component / Standard (Total Points)	Score	Comments
		population. For the test comparing 2015 and 2016 rates, the numerator and denominator for Fisher's test do not match numbers in results Table for 2015/2016 comparison. Recommendation: Adjust values so that chi square, z-test, or Fisher's exact tests contain same values as reported values for 2016 and 2016.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Measurement has only two re-measurement periods, thus sustainment cannot be judged.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	0
Step 10		
10.1	NA	NA
Verify	NA	NA
TOTAL		

Project Score	90
Project Possible Score	91
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**WellCare**
Name of PIP:	**ACCESS TO CARE**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic selected through data collection and noted on page 2.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is documented on page 4 of the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined on page 5.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure is focused on processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Relevant populations are included.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire population captures all relevant enrollees.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed on page 7.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data collection uses programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions are directly related to barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement 1 are reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data is included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology according to HEDIS utilized.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	AAP rate decreased from baseline to follow-up. **Recommendations:** Continue ongoing member, provider, and plan interventions to improve rate.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to evaluate.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to evaluate.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Only baseline and remeasurement results presented, thus sustainment cannot be evaluated.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	84
Project Possible Score	85
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**WellCare**
Name of PIP:	**IMPROVING DILATED RETINAL EXAM (DRE) SCREENING- CLINICAL**
Reporting Year:	**2017**
Review Performed:	**2018**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic selected through data collection and noted on pages 2 and 3.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addresses enrollee care and service.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All enrolled populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study question is documented on page 4 of the report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined on page 5.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Measure is focused on processes of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Relevant populations included.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire population captures all relevant enrollees.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling not used.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected is documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are listed on page 7.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data collection uses programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Consistent and accurate data is collected.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Analysis is listed as annually.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Detailed information regarding staff and personnel are provided in the report.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions are directly related to barriers identified.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline rate only is reported.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data is included in the report.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Baseline data only.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Baseline data only.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Baseline data only.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline data only.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline data only.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	NA

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	NA	NA
8.4	1	1
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify		
	NA	NA

Project Score	**78**
Project Possible Score	**78**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name:	**WellCare**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2017**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® TECHNICAL SPECIFICATIONS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	This was verified and meets all review requirements.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA certified software application Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	NA	NA
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR Survey Validation Worksheet

Plan Name	**WellCare**
Survey Validated	**CAHPS CHILD CCC**
Validation Period	**2018**
Review Performed	**2018**

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. WellCare has a sample size of 3,305. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures are used to select the sample. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol and are clear and appropriate. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 22.5% which is higher than last year's response rate of 17.7%. The target response rate according to NCQA is 40.0%. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult* *Recommendation: Implement strategies to increase response rates to meet NCQA target response rate.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures followed. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data analyzed. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult* *CAHPS Analysis SC CAID 2017*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests conducted. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions are supported by findings. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 22.5%, which is an improvement from 2017 rate of 17.7%. The target response rate according to NCQA is 40.0%, thus, use caution when generalizing the results to the population. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
7.4	What conclusions are drawn from the survey data?	The adult survey improved in 12 out of 17 composite areas and measures, including key areas improving above the 3% market CAHPS improvement goal. Improvements in Rating of Health Care, Shared Decision Making (79%), Rating of Personal Doctor (82.3%), Providing Needed Information (86.2%), and Flu Vaccinations (18-64) (43.8%) placed the WellCare of SC plan at, or in some cases above, the *2017 Quality Compass*. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*

	Results Elements	Validation Comments And Conclusions
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information is provided and documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Adult*

CCME EQR Survey Validation Worksheet

Plan Name	**WellCare**
Survey Validated	**CAHPS CHILD**
Validation Period	**2018**
Review Performed	**12/2018**

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are documented clearly. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. WellCare has a sample size of 3363-75 ineligible which is 3,288. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures are used to select the sample. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol and are clear and appropriate. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 18.6%, which is an increase from last year's response rate of 13.0%. The target response rate according to NCQA is 40.0%. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD* *Recommendation: Implement strategies to increase response rates toward the NCQA goal of 40%.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures followed. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data analyzed. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD 2018 CAHPS Assessment 2018.pdf*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests conducted. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions supported by findings. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - CHILD*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 18.6%. The target response rate according to NCQA is 40.0%, thus, use caution when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The goal was to improve at least 3% for each measure or attribute. WellCare met goal in 4 out of 12 areas and achieved a percentage increase overall in 8 out of 12 areas. WellCare had relevant improvement in key areas such as Rating of Health Care with a 5.1 % increase and an 8% increase in Rating of Health Plan. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – CHILD*; 2018 CAHPS Assessment
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – CHILD*; 2018 CAHPS Assessment

	Results Elements	Validation Comments And Conclusions
7.6	Comparative information about all MCOs (as appropriate).	Comparative information provided and documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – CHILD*; 2018 CAHPS Assessment

CCME EQR Survey Validation Worksheet

Plan Name	**WellCare**
Survey Validated	**CAHPS CHILD CCC**
Validation Period	**2018**
Review Performed	**2018**

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are documented clearly. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. WellCare has a sample size of 1865-32 ineligibles which is 1,833. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures used to select the sample. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol, and are clear and appropriate. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 16.0%, which is higher than last year's response rate of 12.6% but lower than the average response rate from SPH noted as 20.8%. The target response rate according to NCQA is 40.0%. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC* *Recommendation: Implement strategies to increase response rates to meet NCQA target response rate.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures followed. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data analyzed. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC; 2018 CAHPS Assessment*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests conducted. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions supported by findings. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 16.0%. The target response rate according to NCQA is 40.0%, thus, use caution when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The year 2 goal for the child with chronic condition survey is to increase by 3% in all composite measures and attributes. The 2018 results show rates improve in 5 areas for the CCC population. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC; 2018 CAHPS Assessment*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness is part of original survey report. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – Child CCC*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information provided and documented. Documentation: *SPH Analytics 2018 Final Report for WellCare of South Carolina Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**WellCare of South Carolina**
Collection Date:	**2018**

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					WellCare maintains policies by department or functional area within the organization and reviews policies annually. Policies indicate the dates of review, revision, and approval as well as the responsible person and references to related policies. Staff can access policies on the Compliance 360 platform. Policy additions and revisions are communicated to staff in various ways, including via the intranet and compliance notifications. Department leadership is responsible for ensuring staff review new or revised policies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						During the onsite visit, CCME confirmed through discussion with WellCare staff that the WellCare organizational chart does not reflect current staff in several positions. *Recommendation: Update the WellCare of South Carolina organizational routinely for all staffing changes, additions, and position eliminations.*
1.1 *Administrator (CEO, COO, Executive Director);	X					Sonya Nelson is the Interim Plan President. Onsite discussion revealed WellCare is in the final stages of recruitment and hiring for a permanent Plan President and expect the position to be filled in approximately 30 days.
1.2 Chief Financial Officer (CFO);	X					WellCare staff report that Stephanie Williams is the Medicaid Chief Financial Officer (CFO) for the South Carolina plan.
1.3 * Contract Account Manager;	X					Mark Ruise is the Contract Account Manager.
1.4 Information Systems personnel;						Information Systems functions are housed at the corporate offices in Tampa, Florida. Nicholas Barfield, Supervisor of Information Technology (IT), is located in South Carolina and provides local IT support.
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The South Carolina Utilization Management (UM) organizational chart lists Jill Resnikoff as Director of UM. Initial discussion during the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						onsite confirmed this is correct; however, upon further discussion of the need for SC licensure, WellCare staff reported the organizational chart is incorrect and informed CCME that Kelly Jordan oversees UM functions for South Carolina. WellCare staff reported Ms. Jordan is licensed as a Registered Nurse in Arizona. Arizona is part of the Enhanced Nursing Licensure Compact (eNLC), which allows licensed nurses to practice in any state that is part of the eNLC. An updated organizational chart was provided to CCME after the onsite visit.
1.5.1 Pharmacy Director,	X					Nancy Youssef is the Director of Pharmacy and is licensed as a pharmacist by the South Carolina Board of Pharmacy.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Mark DaShiell is WellCare's Director of Quality Improvement.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Staff include a Quality Improvement (QI) Coordinator, a QI Manager, QI Project Managers, QI Specialists, a QI Analyst, Clinical HEDIS Practice Advisors, and Patient Care Advocates.
1.7 *Provider Services Manager;	X					
1.7.1 *Provider Services Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 *Member Services Manager;	X					Onsite discussion revealed Anton Brown serves as Member Services Manager.
1.8.1 Member Services Staff,	X					WellCare contracts with Teleperformance to conduct Member Services functions and provides local oversight to ensure contractual obligations are met.
1.9 *Medical Director;	X					
1.10 *Compliance Officer;	X					Donald Schmadel serves as the Compliance Officer for South Carolina operations.
1.10.1 Program Integrity Coordinator;	X					Matt Calcutti is the Program Integrity Coordinator.
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Taffney Hooks is Manager, Field Regulatory Affairs and Interagency Liaison.
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist or Psychologist;	X					
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					WellCare's internal benchmarks are set to match the clean claims payment requirements of the *SCDHHS Contract*. Internal claims payment audits indicate that WellCare exceeds the SC timeliness requirements by processing 99.72% of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						claims in 30 days and 99.97% in 90 days.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					WellCare and its contracted partners exchange data electronically using the HIPAA electronic transaction standard 837 EDI 5010.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					WellCare receives eligibility files daily as they are made available by SCDHHS and loads the files into systems as they are received. WellCare's systems can identify members and enrollment data across Medicaid and Medicare product lines. Finally, WellCare systems follow a multi-phase verification process to identify duplicate records. When a duplicate record is found, it is held and reviewed manually.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					The *Information Systems Capability Assessment* (ISCA) documentation indicates WellCare has extensive data collection capabilities and functionality to provide reports required by the State. WellCare has thoroughly documented its Healthcare Effectiveness Data and Information Set system, detailing the systems involved, data format, and data flow time line.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					WellCare provided a detailed information security standard that follows the "HITRUST Common Security Framework." The security standard provides personnel with guidance about security controls and risk minimization. Additionally, WellCare provided the results of security assessments of its public facing member portals. The public portal security assessments indicate vulnerabilities; however, no documented

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						corrective measures are provided. *Recommendation: Following a security assessment, document corrective actions that are planned or completed. Documented security assessment corrections, although not an ISCA or SCDHHS Contract requirement, demonstrate an ongoing focus on security improvements.*
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					WellCare follows safe computing practices and limits access to protected health information data to staff who require access.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					WellCare has a very detailed IT disaster recovery plan that addresses overall strategy, staff responsibilities, vendors, incident documentation, and response procedures. WellCare performed a test of the disaster recovery plan in February 2018, resulting in successful recovery of all critical systems.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					WellCare's *Compliance Plan* was submitted for review. Associated policies and procedures also detail compliance processes and requirements.
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				See standards below for identified issues.
2.1 Standards of conduct;						WellCare's *Code of Conduct and Business Ethics* (Code) was most recently approved by the Board of Directors in May 2018. All employees and members of the Board of Directors are expected to read and comply with the Code. A "Code of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Conduct and Business Ethics Acknowledgment" form is found at the end of the Code. Each associate, director, and other individual (temporary associate, etc.) must complete the acknowledgment within 30 days of hire and when the Code is revised.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						Processes for initial and ongoing provider education are defined in WellCare policy. Initial provider orientation includes the Compliance Program, improper payments, excluded entities and individuals, confidentiality, fraud, waste, and abuse (FWA), and the Federal False Claims Act. Compliance training for associates includes the Code, reporting requirements and methods, conflicts of interest, compliance monitoring, communication, investigation, enforcement, information security and privacy, FWA, and the Federal False Claims Act. At the conclusion of training, associates sign an attestation of completion and receive a certificate of completion.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						WellCare's *Corporate Compliance Training Policy (Policy C13-CP-006)* indicates work force members are required to complete compliance training, which includes HIPAA/confidentiality, within 30 days of hire and annually thereafter. Onsite discussion confirmed new employees receive training on confidentiality and HIPAA on the first day of employment during orientation. *Recommendation: Revise Policy C13-CP-006 to include that new employees receive training on confidentiality and HIPAA on the first day of employment.*
2.6 Lines of communication;						
2.7 Enforcement and accessibility;						
2.8 Internal monitoring and auditing;						
2.9 Response to offenses and corrective action;						
2.10 Data mining, analysis, and reporting;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Exclusion status monitoring.						Page 14 of the *WellCare Corporate Compliance Program* states, "The Company, on a monthly basis through a third party vendor, screens current and new Associates, contractors, sales representatives and agents against the Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities and the General Service Administration's System for Award Management exclusion lists and similar state exclusion lists, for those states in which WellCare operates." The document does not specify other required queries for SC, including but not limited to: •*Social Security Death Master File* •*SC List of Excluded Providers* •*SC List of Providers Terminated for Cause* •*Exclusions, Suspensions, and Terminations List* •*Behavioral Health Actions List* *Quality Improvement Plan: Update the WellCare Corporate Compliance Program document to include all queries required for exclusion status monitoring for South Carolina. This can be accomplished via an addendum to the document.*
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Market Compliance Oversight Committee is responsible for oversight of the WellCare of South Carolina's Market Compliance Program. The Market Compliance Officer serves as the committee's chairperson and committee membership includes plan leadership and appropriate representatives from various departments within the organization. The *Market Compliance Oversight Committee*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Charter states the committee reports to the Chief Compliance Officer and the Corporate Compliance Committee. Compliance risks and issues are further reported to the Audit, Finance, and Regulatory Compliance Committee of the Board of Directors. Onsite discussion confirmed this statement refers to the Corporate Board of Directors.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Compliance Department is responsible for investigations of alleged compliance violations. The Special Investigation Unit (SIU) is responsible for investigating allegations of FWA by members, providers and business partners. The *South Carolina - Fraud Waste and Abuse Policy (C13-SIU-FWA-001-SC)* defines processes for FWA detection and investigation. CCME notes that throughout the policy, terms such as "the Department," "Medicaid Fraud Control Unit," etc. are used without being defined. Onsite discussion confirmed the term "Department" refers to SCDHHS and "Medicaid Fraud Control Unit" refers to SCDHHS' Medicaid Fraud Control Unit. *Recommendation: Revise the South Carolina - Fraud Waste and Abuse Policy to define terms that refer to agencies, departments, or units outside of WellCare.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).		X				The *South Carolina - Pharmacy Lock-In Program (Policy SC22-RX-005)* page 2, item 5 states, "New lock-in members…are notified via certified mail at least thirty (30) calendar days prior to the effective lock in date. Those members without a physical address are notified via first class mail." However, the *SCDHHS Contract, Section 11.10.2.1* requires that the initial notification letter and instructions for members placed into the Lock-In Program must be sent by Certified Mail. The *SCDHHS Contract, Section 11.10.3.5* requires health plans to allow a five-calendar day emergency supply of medication to be filled by a pharmacy other than the member's designated pharmacy in case of an emergency. The requirement to allow a five-day emergency supply of medication to be filled by a pharmacy other than the designated lock-in pharmacy is not addressed in WellCare policy. *Quality Improvement Plan: Revise Policy SC22-RX-005 to indicate initial notification letters and instructions are sent to all members via certified mail. Include in the policy that members may obtain a five-calendar day emergency supply of medication from a pharmacy other than the member's designated*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pharmacy in case of an emergency.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				*Policy SC22 OP-CR-001, Credentialing and Re-credentialing* defines the processes used to evaluate the qualifications and practice history of practitioners/physicians, doctorate level practitioners, and allied health professionals. CCME identified the following issues: •The policy does not include all the Program Integrity (PI) queries required by *SCDHHS*; the *Suspension List* and the *Behavioral Health Actions List* are missing. CCME received a corrected policy

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						during the onsite visit, but WellCare needs to ensure it addresses all requirements, and the policy will be evaluated during the QIP process. •The policy does not address whether WellCare is performing federal and state database checks for persons identified on ownership disclosure forms with an ownership or controlling interest as required in the *SCDHHS Contract, Section 11.2.10* and the *SCDHHS Policy and Procedure Guide, Section 11.2*. CCME confirmed during the onsite visit that WellCare is developing a process to address this issue and it will be implemented during the first quarter of 2019. *Policy SC22-OP-CR-024, Medicaid Eligibility Federal and State Sanctions and Opt Out* details various queries required at credentialing and recredentialing but does not address the *SSDMF* or the following PI lists required by SCDHHS: *Suspension List* and *Behavioral Health Actions List*. *Quality Improvement Plan:* *•Update Policy SC22 OP-CR-001, Credentialing and Re-credentialing to include all PI queries required by SCDHHS. Update Policy SC22-OP-CR-024, Medicaid Eligibility Federal and State Sanctions and Opt Out to address queries of the SSDMF, the Suspension List, and the Behavioral Health Actions List.* *•Implement a process to perform federal and state database checks for persons identified on ownership disclosure forms with an ownership or controlling interest as required in the SCDHHS*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Contract Section 11.2.10, and the SCDHHS Policy and Procedure Guide Section 11.2.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Credentialing Committee is chaired by Dr. Robert London, Senior Medical Director. Other voting members of the committee include four network physicians with specialties in cardiology, hematology/oncology, family medicine and pediatrics, and a licensed clinical social worker representing behavioral health. The committee meets monthly and a quorum is met with at least two voting members plus the committee chairperson. Meeting minutes show the quorum met at all meetings. Two physicians do not appear to be attending the committee meetings frequently and Dr. London indicated during the onsite visit that he has discussed attendance issues and these members are working to improve attendance.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List;			X			Credentialing files do not show evidence the following PI queries required by *SCDHHS* were performed: *Terminated for Cause List*, *Suspension List*, *Behavioral Health Actions List*. The plans are no longer required to query the *CMS Adverse Action Report List* per *SCDHHS*. *Quality Improvement Plan: Ensure credentialing files contain proof of all Program Integrity queries required by SCDHHS.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Ownership Disclosure form.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List;			X			Recredentialing files do not show evidence the following PI queries required by *SCDHHS* were performed: *Terminated for Cause List*, *Suspension List*, *Behavioral Health Actions List*. The plans are no longer required to query the *CMS Adverse Action Report List* per *SCDHHS*. *Quality Improvement Plan: Ensure recredentialing files contain proof of all Program Integrity queries required by SCDHHS.*
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					WellCare ensures that a provider's quality-monitoring and quality-review information is incorporated into the credentialing peer review process as defined in *Policy SC22 OP-CR-010, SC - Quality Review*. Quality issues are provided to the Credentialing Department for consideration. CCME confirmed during the onsite visit that gap in care reports are given to providers monthly. Providers also receive dashboard reports, HEDIS measures reports, and CAHPS data among other reports.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					The guidelines and procedures for identifying, investigating, tracking, trending, and reporting potential and actual quality of care issues are defined in *Policy SC22 HS-QI-015, Quality of Care Issues*. Issues are tracked and trended by volume or occurrence and submitted for review and incorporation into the peer-review process. *Policy SC22 OP-CR-020, SC - Hearing and Appellate Review* states that all confirmed quality of care or conduct issues are referred to the SC Credentialing Committee for peer-review determination. In the event the recommendation of the SC Credentialing Committee imposes corrective action that alters a practitioner's relationship with the plan up to and including

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						termination, the practitioner is entitled to a second level, appellate review.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.			X			*Policy SC22 OP-CR-009, SC - Assessment of Organizational Providers* defines the credentialing/recredentialing guidelines for organizational providers. The policy is detailed; however, it does not address all the PI queries required by *SCDHHS* such as the *Suspension List*, and the *Behavioral Health Actions List*. The organizational credentialing and recredentialing files do not reflect proof of the following required queries: *Termination for Cause List, Suspension List* and *Behavioral Health Actions List*. *Quality Improvement Plan: Update Policy SC22 OP-CR-009, SC - Assessment of Organizational Providers, to include all Program Integrity queries required by SCDHHS and ensure proof is in the credentialing and recredentialing files.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.			X			*Policy SC22 OP-CR-046, Ongoing Monitoring of Providers* defines the process of ongoing monitoring for participating providers. The policy states that in addition to providers being checked during initial and recredentialing, all current participating providers are monitored monthly. In the previous EQR, the *Termination for Cause List* and the *Social Security Death Master File* queries were missing from the policy. WellCare submitted a revised policy for the QIP showing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						both queries added; however, the policy for this review does not include the SSDMF even though CCME confirmed during the onsite visit that the plan is querying the *SSDMF*. The policy does not include all the PI queries required by *SCDHHS*: The *Suspension List* and *Behavioral Health Actions List* are missing. *Quality Improvement Plan: Update Policy SC22 OP-CR-046, Ongoing Monitoring of Providers to include the following queries: SSDMF, Suspension List, and Behavioral Health Actions List.*
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.		X				The performance standards for determining geographic provider access for Medicaid members are defined in *Policy SC22 OP-NI-001, SC - GeoAccess Reporting*. PCPs are measured within 30 miles/45 minutes of a member's home. Also, in consideration is a ratio of 1 of each type of PCP (Family/General Practitioners, Internal Medicine, and Pediatricians) per 1,500 members. OBGYNs acting as PCPs are included. The policy has a table of required network providers that includes the provider status code; however, this table is no longer relevant because the *SCDHHS Policy and Procedure Guide, Section 6.2* contains a new

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						table called, "Network Adequacy Chart Service Groups Facility Providers." The *2017 Medicaid Quality Improvement Program Evaluation showed 100% of PCPs met the 90% goal of members having access within 30 miles.* During the onsite visit, WellCare indicated it is using taxonomy in the network evaluation process. CCME suggested WellCare have a policy that describes its network evaluation process. *Quality Improvement Process: Ensure Policy SC22 OP-NI-001, SC - GeoAccess Reporting is updated to include WellCare's current process of utilizing GeoAccess Reports. Ensure WellCare has a policy that describes its provider network evaluation process.*
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					*Policy SC22 OP-NI-001, SC - GeoAccess Reporting* states that specialty providers (including hospitals) are measured within 50 miles/75 minutes. High-volume specialists and high-volume behavioral practitioners are also measured with a ratio of 1 provider per 5,000 members. The *2017 Medicaid Quality Improvement Program Evaluation* shows the following categories met the 90% goal of members having access within 50 miles: specialists (95.29%); pharmacy (100%); behavioral health (98.37%); and hospitals (100%).
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The *2017 Medicaid Quality Improvement Program Evaluation* addresses member cultural needs and preferences. One of the goals is to access the cultural, linguistic, ethnic, and racial needs of the membership and adjust the network as necessary to meet membership needs. The plan educates provider partners through training and surveys to recognize and conduct themselves in a sensitive manner when encountering the cultural and linguistic differences of the members they serve. The plan also tracks grievance data to identify and assess potential non-compliance opportunities aligned with cultural competency. *Policy SC22-GOV-PD-005, SC Cultural Competency* states that WellCare shall have a comprehensive written Cultural Competency Plan (CCP) and a summary will be distributed to network providers. The summary includes information on how the provider may access the full CCP on the WellCare website. The *Provider Manual* has information regarding cultural competency, and it is posted to the website; however, CCME confirmed during the onsite visit that a separate, full CCP is not posted to the website. *Recommendation: Ensure Policy SC22-GOV-PD-005, SC Cultural Competency is updated to accurately address information regarding the Cultural Competency Plan.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					
3.Practitioner Accessibility						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				*Policy SC22 OP-NI-002, SC Provider Appointment and After-Hours Coverage* states the Company will monitor the timeliness of access to care within its provider networks via Appointment Accessibility and After-Hours telephone surveys per requirements outlined by regulatory agencies, contractual requirements, and/or accrediting bodies. However, the policy does not address the benchmark or goal that providers must achieve to be considered in compliance. Provider appointment access standards are listed in the policy, *Provider Manual*, and *Member Handbook* and comply with contract guidelines. Results of the provider access and availability audit are detailed in the *2017 Medicaid Quality Improvement Program Evaluation* and the *2017 South Carolina Medicaid-Accessibility of Services Report*. Appointment availability and after-hours access audits are performed by a contracted vendor semi-annually to ensure members can

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						access providers within those specific appointment availability timeframes. The audits were conducted May-August and October-January for PCPs, specialists, NCQA Oncology, NCQA OB/GYN, and behavioral health providers. Results varied by provider type and standard. Accessibility compliance for some appointment standards did not meet the health plan goal of 90%, but corrective action was addressed for non-compliant providers per onsite discussion. A *Provider Relations Action Plan* is detailed in the *2017 South Carolina Medicaid-Accessibility of Services Report*. *Quality Improvement Plan: Update Policy SC22 OP-NI-002, SC Provider Appointment and After-Hours Coverage to address the benchmark or goal that providers must achieve to be considered in compliance with provider appointment and after-hours access standards.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					As part of the annual EQR process for WellCare, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by WellCare, from which a population of 2.909 unique PCPs was identified. CCME randomly selected a sample of 286 providers from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with contracted providers. The *Telephonic Provider Access Study* calls were answered successfully 68% of the time (163 out of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						241) when omitting calls answered by personal or general voicemail messaging services. When compared to 2017 results of 60%, the 2018 study has a statistically significant increase in successful calls (p=.03). For calls not answered successfully (n=78 calls), 42 (54%) were unsuccessful because the provider was not at the office or phone number listed. Of the 163 successful calls, 149 of the 156 providers (96%) who responded to the question indicated they accept WellCare, although two (1%) indicated that this occurred only under certain conditions. Of 150 responses, 116 (77%) responded that they are accepting new Medicaid patients. Regarding a screening process for new patients, 52 (45%) of the 115 providers that responded to the item indicated that an application or prescreen was necessary, with 21 (43%) indicating that an application must be filled out, whereas 14 (29%) require a review of medical records before accepting a new patient, and 6 (12%) required both. When the office was asked about the next available routine appointment, 77 (70%) of the 110 responses met contact requirements.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.		X				*Policy SC22 HS-PR-001, South Carolina-Provider Training and Education* addresses training for all providers and their staff. WellCare's Provider Relations Representatives conduct initial

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						orientation at the provider's office within 30 calendar days for a newly contracted provider, or when first available. A *Provider In-Service Checklist* is used for each orientation session and outlines all topics covered. This list is signed and dated by the provider, along with a list of participants who were present. The South Carolina WellCare website has a training section for Medicaid providers. There are required trainings listed for Provider Orientation and Cultural Competency; however, the Provider Orientation on the website is for WellCare of Kentucky. https://www.wellcare.com/South-Carolina/Providers/Medicaid/Training *Quality Improvement Plan: Update the provider training website link to reflect the South Carolina Provider Orientation training document.*
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Training sessions in several regional locations throughout the State occur as least once a year for network providers and subcontractors. Additional training is accomplished through orientations, newsletters, email, faxes, letters, onsite training, or other means. The provider portal on the website contains training modules as well.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					*Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines and Preventive Health Guidelines* states that WellCare will adopt preventive health guidelines (PHGs) that are designed to detect and improve the health status of WellCare members by providing preventive care to screen for a host of acute and potentially chronic illnesses. These guidelines detail interventions for prevention or early detection of disease, recommend frequency and conditions under which interventions are required, and document the scientific basis or recognized source upon which the guidelines are based. The guidelines are reviewed at least once a year and revised as necessary.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					When practice guidelines are formally adopted by the plan, they are distributed to appropriate physicians via newsletters, the website, and the *Provider Manual*.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					WellCare adopts validated evidence-based clinical practice guidelines (CPGs) and uses the guidelines as a clinical decision support tool. The CPGs are based on peer-reviewed medical evidence and are relevant to the population served. Providers are also measured annually for compliance with the CPGs. Approval of the CPGs occurs through several committees before posting to WellCare's website. *Policy SC22 HS-QI-009, SC - Provider Clinical Practice Guidelines and Preventive Health Guidelines* defines the process of evaluation and adoption of practice guidelines.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					When practice guidelines are formally adopted by the plan, they are distributed to appropriate physicians via newsletters, the website and the *Provider Manual*.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					*Policy SC22 HS-UM-019, SC - Care Coordination Continuity of Care and Transition of Care* addresses processes for ensuring care coordination, continuity of care, and transition of care for members. PCPs are monitored via HEDIS visits and through over- and under-utilization review.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					WellCare conducts a review of contracted practitioner office medical records as defined in *Policy SC22 HS-QI-005, Medical Record Review*. The medical record review is conducted annually to assess the quality of care delivered and documented. If results are below the benchmark of 80%, an additional sample of records may be selected for review and a corrective action plan is issued, if needed.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Results of the *2018 Adult Medical Record Review Audit* show providers passed with an average final score of 97% which is a 4% rate increase from the 2017 audit results. The *2018 Child Medical Records Review Audit* shows providers passed with an average final score of 96%, which reflects a 3% rate increase from the 2017 audit results. The *2018 Annual Medical Review Audit* reveals zero (0) providers who failed to meet the 80% passing score.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					As stated in the *Medicaid Customer Service Disclosure of Rights and Responsibilities Policy (SC22-OP-CS-023)*, member rights information is provided to newly enrolled members and to newly contracted providers. Verbal information about member rights is provided by Customer Service Representatives as needed when engaging with members. WellCare ensures all staff comply with member rights.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:		X				The *SCDHHS Contract, Section 3.13.2.2* allows a 30 calendar-day timeframe from receipt of enrollment information from SCDHHS for provision of new member materials. During onsite discussion about the plan's timeframe to send member educational materials to new members, disagreement was noted among WellCare staff: some staff reported the materials are sent within 5 business days of receipt of enrollment information from SCDHHS, while others reported the timeframe as within 14 calendar days of receipt of enrollment information. Plan policies contain discrepancies in the timeframe to send new member materials: •*Policy SC22-OP-EN-001, New Member Materials* states, "The Plan will provide the member with a Member Handbook no later than fourteen (30) calendar days from the Plan's receipt of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Enrollment data from SCDHHS." •*Policy SC22-HS-QI-012 South Carolina - Early Periodic Screening Diagnosis and Treatment (EPSDT)* states, "All eligible members shall be informed of the EPSDT program within fourteen (14) business days of enrolling in the health plan through the member handbook." WellCare reported during the onsite visit that as of mid-year 2018, it no longer sends a printed *Member Handbook*; instead, WellCare sends a *Quick Start Guide* that provides basic information about benefits, copayments, etc. and instructions to obtain the *Member Handbook* online or to request a copy from Member Services. Plan policies do not reflect the change in process of sending a *Quick Start Guide* instead of a *Member Handbook*. A *Change Control Log* for the *Member Handbook* is found on WellCare's website. *Quality Improvement Plan: Determine the timeframe of sending member educational materials to new members and revise any applicable documents, policies, etc. with the timeframe. Update all applicable documents to reflect the new process of sending the Quick Start Guide in lieu of the Member Handbook. Revise the documents to reflect that members are instructed they may obtain a Member Handbook online or by contacting Member Services.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						Prior approval is required for members to obtain second opinions at no cost from an out-of-network provider. Page 38 of the *Member Handbook* provides information about second opinions. As written, it is not clear that to obtain a second opinion at no cost from an out-of-network provider, prior approval from the health plan is required: •The first paragraph of the section under the heading "Second Medical Opinion" states, "Call your PCP when you want a second opinion about your care. He or she will ask you to pick another doctor in our network. If you can't find one, don't worry. You'll be able to choose a doctor outside of our network. (You won't have to pay for this.)" •The third paragraph in the section states, "You may have to pay for services you get outside of our network without approval." *Recommendation: Revise the information on page 38 of the Member Handbook regarding second opinions to clarify that in order to obtain a second opinion at no cost from an out-of-network provider, prior approval from the health plan is required.*
1.2 How members may obtain benefits, including family planning services from out-of-						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The *Member Handbook* states that the PCP is the primary contact for all needed care. Members are informed the health plan will assign a PCP if the member does not choose one. Methods for choosing a PCP are discussed. Also included is information that the member may change their PCP at any time.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 Procedures for disenrolling from the MCO;						Appropriate information about disenrolling from the health plan is included in the *Member Handbook*.
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The *Member Handbook* includes ways to locate a provider, such as the online provider search tool, contacting Member Services, and the printed *Provider Directory*. The searchable online *Provider Directory* displays languages spoken, including English, and the print *Provider Directory* displays languages spoken other than English.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The toll-free telephone number and TTY number are provided, as well as a hyperlink to contact Member Services online. WellCare's website supplies the mailing address and offers an online "Contact Us" form for members to submit.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						The *Member Handbook* informs members of methods to report suspected fraud, waste, and abuse to WellCare by telephone and online. Additionally, members are informed they may report suspected fraud, waste, and abuse directly to SCDHHS by telephone or by email. Appropriate contact information is provided for each reporting method.
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Members are notified annually of their right to request a *Member Handbook* or *Provider Directory*. Evidence of the most recent notification is found in the Volume 2, 2018 *Member Newsletter*.
3. Members are informed in writing of changes in benefits and changes to the provider network.		X				*Policy SC22-PD-002, Covered Service Policy* states WellCare will "Notify its current Medicaid Managed Care Members at least thirty (30) days prior to discontinuation of or modification to the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						approved additional services made during the Contract year following approval by the Department." The policy does not address notification to members of changes in core benefits/services. *Policy SC22-OP-EN-007, Member Notification of Specialist Termination* defines appropriate processes to notify members of a provider's termination. *Quality Improvement Plan: Revise the Covered Service Policy (SC22-PD-002) to include processes to notify members of changes to core benefits/services.*
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Member materials are written at a 6th grade reading level as determined by the Flesch – Kincaid scoring method. WellCare has defined processes to make member educational materials available in foreign language versions when needed and in compliance with *SCDHHS Contract* requirements. All foreign language translations are certified with an affidavit of accuracy and reading level compliance by a professional translation service. Member materials are also available in alternative formats, such as Braille, large print, audio CD, and verbal explanation for members with special needs, such as visual impairments or limited reading ability. Members can contact Customer Service to request materials in alternative formats or languages.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					WellCare has engaged a vendor (Teleperformance) to provide Member Services call center functions. Call center operations are conducted in South Carolina. Local vendor oversight is conducted to ensure compliance with contractual obligations. The call center meets contractual requirements for hours of operation. Outside of normal business hours, an automated system provides instructions for emergencies and provides an Interactive Voice Response system 24 hours a day, seven days a week. This system allows members and providers to verify eligibility and claim status, order over the counter products, request a provider or pharmacy list, etc. Callers can also leave confidential voice messages to which a response is provided the next business day. The Nurse Advice Line and the Behavioral Crisis Hotline are available to provide medical advice 24 hours a day via a toll-free telephone number. Member Services call center staffing, call monitoring, and service level requirements are defined in the *Medicaid Customer Service Requirements Policy (SC22-OP-CS-001)* and are compliant with *SCDHHS Contract* requirements.
III C. Member Enrollment and Disenrollment						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					As noted in the *Policy SC22-OP-EN-005, Disenrollment*, SCDHHS/Healthy Connections Choices is responsible for disenrollment actions to remove a member from the Plan. WellCare refers members requesting disenrollment to SCDHHS or Healthy Connections Choices. When WellCare is notified of a member's request to disenroll, Retention Specialists reach out to the member to resolve any issues resulting in the member's request to disenroll.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					The *Member Handbook* and WellCare's website communicate available Case Management and Disease Management programs. The *Member Handbook* communicates information about EPSDT services and encourages members to obtain the recommended services. The handbook also provides information about Preventive Health Guidelines, including recommended services and immunizations, frequency, and timeframes for adults and children. The WellCare website includes the *WellCare of South Carolina Healthy Rewards Program* document defining recommended services and frequency of the services. Other methods to encourage members to utilize preventive health services include mailings and calls. WellCare provides incentives to members to participate in the recommended services by

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						offering monetary rewards in the form of pre-paid gift cards.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					As stated in *Policy SC22-HS-QI-012, South Carolina - Early Periodic Screening Diagnosis and Treatment (EPSDT)*, "Eligible members who have not had a visit for a child health screening…are identified electronically on a monthly basis via claims and encounter data." Periodicity letters are mailed to eligible members who have missed a recommended service, and reminders are mailed during the member's birth month. Providers receive a monthly member list of children who have not had an encounter within 120 days of joining the plan or who are not in compliance with the EPSDT recommended services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					WellCare conducts and participates in community events to provide risk and wellness information to members and the public at-large. Member attendance is recorded and tracked.
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and	X					WellCare contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct the Child and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
services. This assessment includes, but is not limited to:						Adult surveys. The Child survey response rate increased to 18.5% and the Adult response rate increased to 22.5%. The Children with Chronic Conditions response rates increased to 16.0%. All response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%. *Recommendation: Continue working with vendor to increase response rates. Consider options such as adding reminders to the call center and maximizing oversampling to increase response rates.*
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					SPH Analytics summarizes and details results from the Adult and Child surveys, and WellCare analyzes the vendor's reports.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					WellCare's *2018 CAHPS Assessment* provides evidence of analysis, discussion, and initiatives to address problematic areas of member satisfaction.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The 2018 CAHPS survey results were reported to providers via the 2018 Q4 *Provider Newsletter*. This newsletter is available on WellCare's website.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The *2018 CAHPS Assessment* notes "The QIC Committee reviewed the high-level market assessment analysis and approved on 8/27/2018." However, WellCare did not submit QIC minutes for 08/27/18. CCME discovered during onsite discussion that the date is mistyped and should have reflected a meeting date of 9/4/2018 instead of 8/27/18.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Grievance processes are defined *in Policy SC22-OP-GR-001, Medicaid Grievance Policy*.
1.1 The definition of a grievance and who may file a grievance;		X				The *Member Handbook*, *Provider Manual*, and website appropriately define the term "grievance." *Policy SC22-OP-GR-001* defines a grievance using out-of-date terminology. It states a grievance is "an expression of dissatisfaction about any matter

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						other than an action." The correct terminology is "adverse benefit determination" rather than "action," as specified in *42 CFR §438.400 (b)* and the *SCDHHS Contract, Section 9.1 (a)*. *Policy SC22-OP-GR-001* indicates grievances can be filed by a member, a member's representative, or a provider on behalf of a member (with written consent). Appropriate information about who can file a grievance is found in the *Provider Manual*, the *Member Handbook*, and on the website. Page 63 of the *Member Handbook* indicates the *Appointment of Representative* form is available on the website at www.wellcare.com/South-Carolina. A search of the website does not result in finding the form on the Medicaid section of the site. *Quality Improvement Plan: Revise the definition of a grievance in Policy SC22-OP-GR-001 to include current terminology as specified in 42 CFR §438.400 (b) and the SCDHHS Contract, Section 9.1 (a). Update WellCare's Medicaid website to include the Appointment of Representative form.*
1.2 Procedures for filing and handling a grievance;	X					Page 98 of the *Provider Manual* states members may file grievances "at any time after the date of the dissatisfaction and during the period in which the Member has active coverage by WellCare." The requirement that grievances must be filed "during the period in which the Member has active coverage by WellCare" is not stated in *Policy SC22-OP-GR-001*, the *Member Handbook*, or on the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						website, and no restrictions which limit grievances to be filed by current enrollees only are defined in the *SCDHHS Contract* and *42 CFR §438 Subpart F—Grievance and Appeal System*. *Policy SC22-OP-GR-001* defines a second-level grievance review for member dissatisfaction with the outcome of the first-level review if related to an ability to receive benefit coverage, access to care, access to services, or payment for care of services. The policy indicates second-level reviews follow the same process and procedures as the first-level review but are conducted by staff not involved in the initial review. The *Grievance Resolution Letter* template states, "You must request your second review within 30 calendar days of the date of this letter." This limitation on the filing timeframe is not stated in *Policy SC22-OP-GR-001*, the *Member Handbook*, the *Provider Manual*, or on the website. Onsite discussion revealed the 30-day filing timeframe for a second-level grievance review is mandated by NCQA. *Recommendation: Remove the statement on page 98 of the Provider Manual that indicates members must be actively covered by WellCare in order to file a grievance. Update Policy SC22-OP-GR-001, the Member Handbook, the Provider Manual, and the website to include the filing timeframe for a second-level grievance review.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of a grievance;	X					Page 6 of *Policy SC22-OP-GR-001* states, "If a grievance decision is extended, the plan must provide written notification and the reason for the delay." This applies only to extensions requested by the health plan and not to member-requested extensions. Also, there is no mention that the health plan must make reasonable attempts to provide verbal notice of the extension or that the written notice of the extension must be provided within two calendar days. Page 64 of the *Member Handbook* addresses written notification of a plan-requested extension but does not address the requirement of an attempted verbal notification. *Recommendation: Revise Policy SC22-OP-GR-001 to indicate member notification of an extension is required only when the plan requests the extension. Ensure Policy 22-OP-GR-001 and the Member Handbook include the timeframe for written notification of a health plan-requested extension and that the health plan must make reasonable attempts to provide verbal notice of the extension in addition to the written notification.*
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.	X					Grievance files reflect staff send acknowledgement letters consistently, resolve grievances within the required timeframe, and grievant notification of resolution is provided within the required timeframe. CCME found no widespread issues in the grievance files; however, a few issues of concern are noted: •File sample number 99—the member's complaint was not investigated fully before closing the grievance. •File sample number 96—the resolution letter uses an acronym that the member may not understand multiple times without defining the acronym. •File sample number 28—the file contains information that the issue was referred to another WellCare department to assist with resolution; however, it contains no documentation of actions taken by that department to resolve the grievance. Many of the grievance resolution letters contain grammatical errors. *Recommendation: Ensure grievance staff thoroughly investigate the issues within the grievance. When grievances are referred to another WellCare department, ensure all actions taken by that department to resolve the grievance are documented within the grievance*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						file. Avoid using acronyms that members may not understand in grievance resolution letters. Implement a process to review grievance resolution letters for grammatical and syntax errors prior to mailing.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.		X				*Policy SC22-OP-GR-001* states grievances are reported monthly, quarterly, and annually to Company management. The policy also indicates grievance data is reported to the Customer Service Quality Improvement Workgroup, the Medical Advisory Committee, and Quality Improvement Committee. CCME confirmed during the onsite visit that grievance data is reported to these committees quarterly. UMAC meeting minutes confirm grievance data and information was reported during the meetings held on August 10, 2017 and November 12, 2018. Reporting of grievance data and information could not be identified in the minutes from meetings held on November 14, 2017, March 19, 2018, June 11, 2018, and August 13, 2018. Minutes from three of the four UMAC meetings contain a statement that "the grievances report was not submitted…" Additionally, the "Grievances" tab of the *2018 Quality Improvement Work Plan* indicates grievance data is "unavailable" for 2017 and quarters 1 and 2 of 2018. The "Comments" fields all state "Unavailable data will be presented next quarter." *Quality Improvement Plan: Ensure grievance data is reported to the Utilization Management*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Advisory Committee as stated in Policy SC22-OP-GR-001. Ensure the Quality Improvement Work Plan is routinely updated to include quarterly grievance data.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					WellCare's *2018 Medicaid Quality Improvement Program Description* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The Board of Directors provides strategic direction and ultimate authority for the QI Program.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					Monitoring provider compliance with preventive health and clinical practice guidelines was added as an objective for the QI Program. The *2018 QI Work Plan* addresses the monitoring of compliance with the guidelines; however, the specific guidelines monitored are not addressed, and the monitoring frequency is listed as quarterly yet "N/A" is recorded for the first, second, and third quarters. *Policy SC22-HS-QI-009, Provider Clinical Practice Guidelines and Preventive Health Guidelines* indicates monitoring is conducted annually. Onsite discussion confirmed monitoring is conducted annually and that Dilated Retinal Exams and Attention-Deficit/Hyperactivity Disorder were chosen for monitoring. *Recommendation: Update the 2018 QI Workplan to reflect the specific guidelines being monitored and monitoring frequency for the provider compliance with the clinical practice and preventive health guidelines.*
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) provides oversight and approval for all QI activities. The Utilization Management Advisory Committee (UMAC) oversees all clinical QI, utilization management, and behavioral health activities. The primary responsibilities for both committees are outlined in the *2018 QI Program Description*.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The membership of the QIC includes senior leadership and other department representatives. Network providers from both primary and specialty care are included in the membership of the UMAC. In the 2017 EQR, CCME recommended that WellCare consider changing the quorum requirements for the UMAC so the chairperson/Medical Director is not considered the tie breaker. This change is reflected in the QI Program Description.
3. The QI Committee meets at regular quarterly intervals.	X					The QIC and UMAC meet quarterly as evident by the committee minutes.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are documented for all meetings.
IV C. Performance Measures						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					WellCare uses Inovalon's Quality Spectrum Insight, a certified software application, for HEDIS measure calculation. The comparison from the previous to the current year reveals a strong increase (>10%) in several measures including Combination 1 Immunizations, Lead Screening, and Medication Management for People with Asthma. One measure, Persistence of Beta-Blocker Treatment After a Heart Attack, shows a substantial (>10%) decrease in the reported rate. Details of the validation of the performance measures may be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Three projects were submitted and validated using the *CMS Protocol for Validation of Performance Improvement Projects*: Improving Dilated Retinal Exam (DRE) Screening, Access to Care, and Improving Hemoglobin A1C Testing.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All projects receive a validation score within the High Confidence range and met the validation requirements. CCME identified documentation errors in the Access to Care and Improving Hemoglobin A1C Testing projects. The recommendations for correcting these errors are found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					WellCare providers receive performance feedback in their Care Gap reports and dashboards.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					WellCare evaluates the effectiveness of its QI Program annually. For this review, the health plan provided the *2017 Medicaid Quality Improvement Program Evaluation*. This report provides an assessment of the of the results of the QI activities conducted during 2017. Some of the reported results appear incomplete or incorrect. For example, the results of the monitoring of provider compliance with the specific appointment availability is displayed on page 10 and page 13. The process WellCare uses for this monitoring indicates that providers found non-compliant during round one of the audits are re-audited in round two. The analysis indicates that for each of the categories measured, none of the appointment standards meet 100%. Round two (re-audit) was not conducted for the non-compliant providers and noted as "N/A" in the results tables. The medical record audits reported on pages 67 through 72 indicate that the sample size for the audit is 200 medical records. The analysis (page 71) indicates the sample is 200 providers instead of medical records. CCME confirmed onsite that for this study, 200 medical records are used in the audit. *Recommendation: When determining the effectiveness of the QI activities, include the results of all activities. If the results are incomplete, notate this in the analysis documentation.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *2018 Utilization Management Program Description* outlines the goals, scope, and staff roles for physical and behavioral health (BH) services for members in South Carolina. Several policies, such as *SC22-HS-UM-025, Service Authorization Decisions Policy* and *SC22-HS-UM-013, Prior Authorization Precertification Review* provide guidance on utilization management (UM) processes and requirements.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				Requirements for UM decision timeframes are described in the *Provider Manual* and detailed in *Policy SC22-HS-UM-025, Service Authorization Decisions* and *Policy SC22-HS-UM-023, Inpatient Concurrent Review*. Page 36 in the Member Handbook incorrectly references the timeframe for member-requested extensions of expedited authorization determinations as up to 48 hours. However, the SCDHHS Contract, Section 8.6.2.3 allows 14 calendar days for member-requested extensions. *Quality Improvement Plan: Revise page 36 in the Member Handbook to indicate expedited service authorizations can be extended up to 14 calendar days, if requested by the member, as required in SCDHHS Contract 8.6.2.3.*
1.5 consideration of new technology;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Program Description* indicates the Corporate Medical Directors and Behavioral Health (BH) Medical Directors assist in developing and implementing the Utilization Management (UM) Program. Their responsibilities consist of, but are not limited to, providing oversight for all physical and BH programs related to authorization and appeals, and participating on the Utilization Management Advisory Committee (UMAC). The 2017 and 2018 UMAC meeting minutes reflect Robert London, MD, and Sultan Simms, MD, actively participate on the UMAC, where UM activities are reviewed and approved.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					Annually, the UMAC evaluates and updates the UM Program for medical and behavioral health services to assess its strengths and effectiveness. The UMAC consists of representatives of the provider network who participate and provide input to the UM Program and work plan. Additionally, the UMAC and the Quality Improvement Committee (QIC) are responsible for evaluating clinical and preventive practice guidelines and adoption of utilization review criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion revealed the UM Program Evaluation was discussed at QIC.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					*Policy SC22-HS-UM-011, Application of Criteria* lists UM standards and evidence-based criteria used for determining medical necessity. WellCare uses the following criteria: InterQual Criteria™, *South Carolina Medicaid Provider Handbooks*, and *WellCare's Clinical Coverage Guidelines*. Individual circumstances and the local delivery system are considered when determining medical appropriateness.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of 15 UM approval files reflects consistent decision making using criteria and use of relevant medical information, as described in the *UM Program Description* and *Policy SC22-HS-UM-011, Application of Criteria.*
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in *Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions*. The criteria for utilization are communicated in the *Member Handbook*, the *Provider Manual* and on the WellCare website. The applicable forms are correctly noted in the *Provider Manual*.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					*Policy SC22-HS-UM-01, Application of Criteria* describes how individual circumstances and clinical information pertaining to cases are reviewed and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						compared to the criteria.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					*Policy SC22-HS-UM-007, Interrater Reliability* and *Policy SC22-RX-008 Quality Assurance in the Pharmacy Department* describe the annual inter-rater reliability (IRR) process for all licensed reviewers, including physicians. Discussions during the onsite visit confirmed the established benchmark is 80% for pharmacy staff and 85% for other clinical reviewers.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions are noted on the *South Carolina Medicaid Comprehensive Preferred Drug List (PDL)*, which identifies over-the-counter (OTC) medications that are covered with a prescription and those requiring prior authorization. Additionally, pharmacy benefit information is available in *Policy C22-RX-011, Medicaid Preferred Drug List*, the *Member Handbook, and* the *Provider Manual*. The *Pharmacy QI Program Description* indicates the Pharmacy and Therapeutics Committee (P&TC) consists of independent clinical pharmacists and physicians who make decisions regarding PDL management activities.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					*Policy, SC22-RX-003, South Carolina - Emergency Medication Overrides Policy* indicates a five-day supply of medication will be approved while a prior authorization request is pending. Additionally, *Policy*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SC22-PD-002, Covered Service Policy provided during the onsite visit describes covered pharmacy requirements.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The *Provider Manual* and the *Member Handbook* adequately describe emergency medical services and post-stabilization services and requirements. During the onsite visit, WellCare provided a recently reviewed version of *Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services*, dated 10/23/18. The policy defines an emergency, but it does not address the post-stabilization requirement regarding the transfer of an individual to another medical facility as required in *SCDHHS Contract, Section 4.2.11.2.7.* *Recommendation: Revise Policy SC22-HS-UM-028, Emergency and Post-Stabilization Services to include the requirements specified in the SCDHHS Contract, Section 4.2.11.2.7.*
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description* and policies such as *SC22-HS-UM-025, Service Authorization Decisions* and *UM.008S, Clinical Criteria* describe staff who are licensed and trained to perform physical and BH clinical reviews. Additionally, it indicates the appropriate Medical Director will render denials and review cases which the UM staff cannot approve.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for UM approval files are consistent with *Policy SC22-HS-UM-025, Service Authorization Decisions Policy* and *SCDHHS Contract* requirements.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of 15 files with adverse benefit determinations reflect decisions are made by an appropriate physician specialist as outlined in *Policy SC22-HS-UM-026, South Carolina - Adverse Determinations Proposed Actions*.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files reveal denial decisions are made according to the processes described in *Policy SC22-HS-UM-026, South Carolina - Adverse Determinations Proposed Actions*.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					*Policy SC22-HS-AP-002, Member Appeals Policy* and *SC22-RX-012, Pharmacy Appeals* outline the appeals processes. Additionally, the *Provider Manual, Member Handbook*, and the member tab on the website provide instructions for the appeal process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definitions of an adverse benefit determination, an appeal, and who may file an appeal are described in *Policy SC22-HS-AP-002, Member Appeals Policy*, the *Provider Manual*, the *Member Handbook* and posted on the website. CCME identified the following issue with *Policy SC22-RX-012, Pharmacy Appeals*: Throughout the policy the term "adverse benefit determination" is referred to as "adverse coverage determination" and the term "appeal" is referred to as "redetermination," despite each having separate definitions. During the onsite visit, WellCare confirmed there is no difference in the meaning of each set of terms and the respective terms are used interchangeably. *Recommendation: Correct Policy SC22-RX-012, Pharmacy Appeals to use current SCDHHS Contract terminology of "adverse benefit determination" instead of "adverse coverage determination" and use "appeal" instead of "redetermination".*
1.2 The procedure for filing an appeal;	X					Instructions for filing an appeal are listed in the *Member Handbook*, *Provider Manual*, *Policy SC22-HS-AP-002, Member Appeals Policy*, *SC22-RX-012, Pharmacy Appeals*, and in the *Initial Adverse Benefit Determination* notices. Page 93 in the *Provider Manual* indicates an *Appointment of Representative* (AOR) statement is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						required to file an appeal on behalf of the member and a link to all forms is provided. CCME did not identify the AOR form on the website. *Recommendation: Update the website to include the AOR form.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					As documented in *Policy SC22-HS-AP-002, Member Appeals Policy*, the *Member Handbook*, and the *Provider Manual*, standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt. Page 10, item VI (2) of *Policy SC22-RX-012, Pharmacy Appeals* states member notification of the appeal decision is provided by mail "within the time frame" but does not specify the timeframe for member notification. Onsite discussions revealed decision timeframes are documented on page 19 in said policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit page 10, section VI (2) in Policy SC22-RX-012, Pharmacy Appeals to indicate member notification of an appeal decision is provided within the timeframes referenced on page 19, item 4 of the policy. Additionally, update page 19 to reflect the determination timeframe includes member notification of the decision.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				Review of appeal files reflect determinations by appropriate physicians and appeal notices contain required information. However, CCME found a few of the appeal files were resolved outside of the resolution timeframe. *Policy SC22-HS-AP-002, Member Appeals* states "the timeframe for the appeal begins with the receipt of the member's initial notification of appeal (oral or written) to the Plan." In three of the files reviewed, the date the appeal was received was recorded as when the written request or authorization was received. The following is a summary of the file issues: •File #10: Oral requested received on 6/11/18 and resolved on 7/21/18. •File #15: Expedited appeal request was received on 12/28/17 and resolved on 1/9/18. •File #16: Written request received on 3/26/17 and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						resolved on 5/2/17. Onsite discussions revealed WellCare begins the timeframe for a member appeal request when written documentation is received. *Quality Improvement Plan: Ensure staff is following the required timeframes for processing appeals, as required in SCDHHS Contract, Section 9.1.4.4.1 and according to Policy SC22-HS-AP-002, Member Appeals.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The 2017 *Care Management Program Description, the 2017 QI Program Evaluation,* and several policies outline the framework for case management/care coordination program goals, objectives, lines of responsibility, and operations for physical and behavioral health services. Onsite discussion confirmed WellCare implemented a population health model in October 2017 which integrates DM and CM services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has processes to identify members who may benefit from case management.	X					The *Care Management Program Description,* the *Provider Manual*, and several policies describe methods which eligible members are identified and referred into case management, such as: review of clinical claims, health risk assessment results, medical records, and utilization management data. Identified members are stratified into low, moderate, or high categories based on results from WellCare's risk stratification model.
3. The MCO provides care management activities based on the member's risk stratification.	X					*Policy SC22-HS-DM-012, Disease Management - Program Operation* describes WellCare's approach to member engagement based on the member's risk level.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Susan Martinez serves as WellCare's Transition Coordinator
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The 2017 *QI Program Evaluation* and the *Measuring Effectiveness of the Complex Case Management Program* report describe the purpose and process used to measure case management effectiveness and member satisfaction. The information obtained is used to assess strengths and weaknesses and improve CM and DM Programs.
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate care management activities are conducted as required, and Case Managers follow policies to conduct the appropriate level of case management. HIPAA verification and identifying care-gaps are consistently addressed. Unable to contact (UTC) letters and education materials are appropriately utilized.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					WellCare analyzed and monitored data, and offered recommendations based on findings for several services regarding utilization in the committee meetings and in the program evaluation.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					WellCare's delegated organizations have written, signed agreements designating the delegated activities with the compliance and oversight requirements included; addendums define any State specific contract requirements. WellCare delegates the following services: •UM – Advanced Medical Review; CareCore National, LLC d/b/a EviCore Healthcare; Health Help, LLC; Progeny Health, Inc. •UM Behavioral Health – Focus Health •Nurse Advice Line – CareNet •Pharmacy – CVS •Customer Service –Teleperformance; The Results Companies; SPH Analytics •Crisis Line – Health Integrated, Inc. •Case Management (OB and High-Risk Pregnancy) – Alere •Vision – March Vision •Credentialing – AU Medical Center; Greenville Hospital System; Integra Partners, IPA; Linkia, LLC; Mary Black Health Network Inc.; Medical University Hospital Authority; Minute Clinic; Preferred Care of Aiken, Inc.; Regional Health Plus LLC; Roper St. Francis Healthcare (CareAlliance Health Services); St. Francis Physician Services; Take Care Clinics; United Physicians, Inc. (formerly Provider Healthlink of South Carolina, LLC); Drynachan LLC (DBA Advance Health); OptumHealth Care Solutions; Palmetto Health University of South Carolina Medical Group; Take Care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Clinics; University Health Link
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				*Policy SC22-CP-AO-007, Delegation Oversight* and *SC22-CP-AO-007-PR-001, Delegation Oversight Procedure* define the functions and processes for oversight of delegated activities. Both the policy and procedure have incorrect references to renamed credentialing policies. CCME received proof of annual or pre-delegation oversight activities for all delegated entities. WellCare's oversight process includes pre-delegation oversight for entities that are under consideration for delegation, annual oversight for current delegates, and monthly and/or quarterly data review with corrective action, as appropriate. Onsite discussion confirmed that as a result of the 2017 EQR findings, WellCare provided training to ensure WellCare employees conducting delegation oversight are aware of South Carolina requirements and are consistent in documenting review findings across the entities reviewed. Improvement is noted in this EQR; however, issues are identified as followed: •For the credentialing/recredentialing file review oversight, a few of the entities show "N/A" for the *Ownership Disclosure Form* standard. WellCare provided evidence that focused reviews were performed to obtain the information after the audit. •The credentialing/recredentialing oversight review form does not address all PI queries that are required

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by *SCDHHS: Termination for Cause List, Suspension List,* and *Behavioral Health Actions List are missing.* *Quality Improvement Plan: Update Policy SC22-CP-AO-007, Delegation Oversight and SC22-CP-AO-007-PR-001, Delegation Oversight Procedure to include the correct references to the credentialing policies. Update the credentialing/recredentialing file oversight review form to reflect all the PI queries required by SCDHHS.* *Recommendation: Ensure Ownership Disclosure Forms are properly addressed during the delegated entity oversight review for credentialing/recredentialing.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 administering required immunizations;	X					As a component of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, WellCare ensures pediatric and adolescent immunization requirements are monitored by reviewing immunization rates for each provider, as described in the *Provider Manual*. HEDIS reports in the 2017 *QI Program Evaluation* details how child and adolescent immunizations are tracked, monitored, and evaluated for improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					WellCare follows the EPSDT periodicity schedule for members through 21 years of age. Provider compliance with providing EPSDT services is monitored through random medical record reviews and letter notifications as noted on page 25 in the *Provider Manual*. HEDIS reports of Well-Child Visits are additional methods used for monitoring EPSDT compliance.
2. Core benefits provided by the MCO include all those specified by the contract.	X					The requirement for newborn hearing screenings as a Core Benefit when rendered to newborns in an inpatient hospital setting is not noted in the *Provider Manual* under Covered Services. Onsite discussion revealed this requirement is documented in the *EPSDT Toolkit*. *Recommendation: Update the Provider Manual to include the Core Benefit requirement for newborn hearing screenings as noted in Section 4.2.18 of the Policy and Procedure Guide for Managed Care Organizations.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			A deficiency identified in the 2017 EQR relating to credentialing was not corrected. WellCare did not implement revisions to *Policy SC22 OP-CR-046, Ongoing Monitoring of Provider* regarding the SSDMF. *Quality Improvement Plan: Ensure that all deficiencies identified in the EQR are corrected*